	FOI	ROHF	USE		

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# 2000 STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2000)

#### IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

	DPH Facility ID Number: 0041210  acility Name: ELMWOOD NURSING & REHABILITATION CENTER,	LLC	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER
C T III D T	ddress: ROUTE 159 & INTERSTATE 70 MARYVILLE Number City  ounty: MADISON  elephone Number: (616) 344-7750 Fax # (616) 344-3588  DPA ID Number: 37-1347516  ate of Initial License for Current Owners: 10/01/95  ype of Ownership:  VOLUNTARY,NON-PROFIT X PROPRIETARY  Charitable Corp. Individual  Trust Partnership  RS Exemption Code Corporation	GOVERNMENTAL State County Other	I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said content: are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider is based on all information of which preparer has any knowledge  Intentional misrepresentation or falsification of any informatior in this cost report may be punishable by fine and/or imprisonment  Officer or Administrator of Provider  (Signed) (Type or Print Name) MAKHLOUF SUISSA  (Title) PRESIDENT  (Signed) (Signed) (Date)
I	"Sub-S" Corp.  X Limited Liability Trust Other  the event there are further questions about this report, please contact:		Paid (Print Name and Title) EDWARD N. SLACK, C.P.A.  (Firm Name FROST, RUTTENBERG & ROTHBLATT, P.C. & Address) 111 Pfingsten Rd., Suite 300, Deerfield, II 60015  (Telephone) (847) 236-1111 Fax # (847) 236-1155  MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1636

STATE OF ILLINOIS Page 2

Facil	ity Name & ID Num	ber ELMWOOD	NURSING & REH	ABILITATION CE	NTER, LLC		# 0041210	Report Period Beginning:	01/01/00	Ending:	12/31/00
	III. STATISTICA	AL DATA					D. How many be	d-hold days during this year were	paid by Public	Aid?	
	A. Licensure/	certification level(s) o	f care; enter numbe	r of beds/bed days,			104	(Do not include bed-hold days	in Section B.)		
	(must agree	with license). Date of	change in licensed	beds							
	, ,	ŕ	Ü			_	E. List all service	es provided by your facility for no	n-patients.		
	1	2		3	4			"meals on wheels", outpatient th	_		
							N/A	,	FJ /		
	Beds at				Licensed		1012				-
	Beginning of	Licensu	re	Beds at End of	Bed Days During		F Does the facilit	ty maintain a daily midnight cens	us? YE	S	
	Report Period	Level of		Report Period	Report Period		r. Does the facili	ty maintain a daily midnight cens	us. <u>11</u>		-
	Report 1 eriou	Level of	Care	Keport i eriou	Keport i eriou		C Do nages 2 &	4 include expenses for services or			
1	53	Skilled (SNI	E/	53	19,398	1	1 0	ot directly related to patient care			
2	33		atric (SNF/PED)	33	17,376	2	YES	NO X	•		
3	51	Intermediat		51	18,666	3	LLS	110			
4	31	Intermediat		31	10,000	4	H Does the RAI	ANCE SHEET (page 17) reflect a	ny non-caro acc	ote?	
5		Sheltered C				5	YES YES	NO X	iny non-care ass	cts.	
6		ICF/DD 16				6	120				
		101/22 10	01 2000			<del>                                     </del>	I. On what date of	lid you start providing long term	care at this loca	tion?	
7	104	TOTALS		104	38,064	7	Date started	10/01/95			
							J. Was the facilit	y purchased or leased after Janua	ary 1, 1978?		
	B. Census-Fo	r the entire report per	riod.				YES	Date 10/01/95	NO		
	1	2	3	4	5				·		
	Level of Care	Patient Days	by Level of Care an	d Primary Source of	f Payment		K. Was the facili	ty certified for Medicare during t	he reporting yea	r?	
		Public Aid					YES	NO II	YES, enter nun	ıber	
		Recipient	Private Pay	Other	Total		of beds certifie	ed 13 and day	s of care provid	ed	1,682
8	SNF	2,715	173	1,682	4,570	8					
9	SNF/PED					9	Medicare Interm	ediary ADMINISTAR OF KE	NTUCKY		
10	ICF	27,441	2,248	90	29,779	10					
	ICF/DD					11	IV. ACCOUNTI	NG BASIS			
	SC					12		MODIFIED			-
13	DD 16 OR LESS					13	ACCRUAL	CASH*	CA	SH*	
14	TOTALS	30,156	2,421	1,772	34,349	14	Is your fiscal ye	ar identical to your tax year?	YES X	NO	]
		ccupancy. (Column 5, on line 7, column 4.)	line 14 divided by to 90.24%	otal licensed -			Tax Year: * All facilities oth	12/31/00 Fiscal Year: ner than governmental must repo	12/31/00 rt on the accrua	basis.	

	STATI	E OF ILL	INOIS				Page 3
Facility Name & ID Number	ELMWOOD NURSING & REHABILITATI	#	0041210	Report Period Beginning:	01/01/00	Ending:	12/31/00

					11)	0071210	Keport i criou	Deginning.	01/01/00	Enumg.	12/31/00	-
	V. COST CENTER EXPENSES (through				oliar)	Reclass-	Reclassified	Adiust-	Adjusted	FOR OHE	LISE ONLY	T
	3   Housekeeping											
		1	2							9	10	
1		119,489	19,128								10	1
2	Food Purchase	, , ,		- )-		(3,338)		(85)				
3	Housekeeping	87,360	7,263		94,623	( ) ,		( )	94,623			3
4	Laundry	37,639	14,781		52,420		52,420		52,420			4
5	Heat and Other Utilities			87,103	87,103				87,103			5
6	Maintenance	43,100	4,694	24,281	72,075		72,075	1,427	73,502			6
7	Other (specify):*											7
8	TOTAL General Services	287,588	166,463	116,711	570,762	(3,338)	567,424	1,342	568,766			8
9												
10		1,166,736		140				7,133				
10a	1 5											
11			7,312						,-			
12		51,886		8,004	59,890		59,890		59,890			
13	2											
	2 1											
15	Other (specify):*							1,368	1,368			15
16		1,256,182	85,729	22,583	1,364,494		1,364,494	8,501	1,372,995			16
				**				(440.505)	1/80/0			
		51,073		234,000	285,073		285,073	(119,205)	165,868			
18								(1.5.10.5)				
19					- /-		- /-		,			
20		<b>7</b> 4 220	20.040									
21		51,338	30,949		)	2 220		(94,850)	,			
22				243,811	243,811	3,338	247,149		247,149			
				1 150	1 150		1 150	247	1 407	ļļ		
										ļļ		
				, , , ,						ļJ		
				05,130	05,130		05,130		,	<b></b>		
27			-	-			-	- /	- ,	<del>                                     </del>		1
28	TOTAL General Administration	Note   Control   Control										
20	TOTAL Operating Expense	1 646 181	283 141	1 101 882	3 031 204		3 031 204	(206 555)	2 824 640			20
23	(Sum of lines 8, 10 & 28)	, ,	,	, ,			3,031,204	(200,333)	4,044,049			43

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

# ELMWOOD NURSING & REHABILITATION CENTER, LLC 0041210 COST REPORT RECLASSIFICATIONS 01/01/00 12/31/00

SCHEDULE V LINE #			
22 EMPLOY	EE BENEFITS	3,338	
2	FOOD	_	3,338
<u>To reclas</u> :	s cost of employee meals from raw	food to emplo	yee benefits
33 REAL ES	TATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Report Period Beginning:

01/01/00

**Ending:** 

Page 4 12/31/00

# V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			23,429	23,429		23,429	63,116	86,545			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,209	33,209		33,209	141,253	174,462			32
33	Real Estate Taxes			38,766	38,766		38,766		38,766			33
34	Rent-Facility & Grounds			380,640	380,640		380,640	(374,809)	5,831			34
35	Rent-Equipment & Vehicles			10,453	10,453		10,453	6,338	16,791			35
36	Other (specify):*											36
37	TOTAL Ownership			486,497	486,497		486,497	(164,102)	322,395			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		53,578	135,718	189,296		189,296		189,296			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,096	57,096		57,096		57,096			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		53,578	192,814	246,392		246,392		246,392			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,646,181	336,719	1,781,193	3,764,093		3,764,093	(370,657)	3,393,436			45

<sup>\*</sup>Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Page 5

4

Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTEL

# 0041210

**Report Period Beginning:** 

01/01/00

12/31/00

**Ending:** 

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

cost was included. (See instructions.)

	In column	n 2 below,	reference the	ine on w	hich the particul	lar co
	NON-ALLOWABLE EXPENSES		1 Amount	2 Refer- ence	OHF USE ONLY	
1	Day Care	\$			\$	1
2	Other Care for Outpatients					2
3	Governmental Sponsored Special Programs					3
4	Non-Patient Meals					4
5	Telephone, TV & Radio in Resident Rooms					5
6	Rented Facility Space					6
7	Sale of Supplies to Non-Patients					7
8	Laundry for Non-Patients					8
9	Non-Straightline Depreciation		345	30		9
10	Interest and Other Investment Income		(13,433)	32		10
11	Discounts, Allowances, Rebates & Refunds					11
12	Non-Working Officer's or Owner's Salary					12
13	Sales Tax		(85)	2		13
14	Non-Care Related Interest					14
15	Non-Care Related Owner's Transactions					15
16	Personal Expenses (Including Transportation)					16
17	Non-Care Related Fees					17
18	Fines and Penalties		(273)	21		18
19	Entertainment		•			19
20	Contributions					20
21	Owner or Key-Man Insurance					21
22	Special Legal Fees & Legal Retainers					22
23	Malpractice Insurance for Individuals					23
24	Bad Debt		(8,853)	21		24
25	Fund Raising, Advertising and Promotional		(2,400)	20		25
	Income Taxes and Illinois Personal		· · · · · · ·			1
	Property Replacement Tax					26
	Nurse Aide Training for Non-Employees					27
28	Yellow Page Advertising		(1,699)	20		28
29	Other-Attach Schedule		(160,188)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$	(186,586)		\$	30

OHE USE (	NI V			
OHF USE C	/11L/ I			
48	49	50	51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

			-	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(184,071)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (184,071)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (370,657)		37

<sup>\*</sup>These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.) 1 2

		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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| STATE OF ILLINOIS
| ELMWOOD NURSING & REHABILITATION CENTER, LLC | 1019 | 0041210 |
| Report Period Beginning: 01/01/00 |
| Ending: 12/31/00 |

Sch. V Line

Deferred Maintenance		NON ALLOWABLE EVBENCES		Sch. V Line Reference	
2 Proce Prote Medical Supples         (14,662)         10         2           4 Incer Prote Legal         (17,74)         19         3           4 Incer Prote Legal         (17,62)         21         4           5 Overfart Bank Charges         (4,482)         21         5           6 Person         (4,482)         21         5           7 Person         (4,482)         32         5           8 Person         (4,682)         10         10           10         (4,682)         10         11           11         (4,682)         10         11         11           12         (4,682)         10         11         11         11         11         11         11         11         11         11         12	_	NON-ALLOWABLE EXPENSES	Amount		
3 Process (assessed assessed asses	1	Deterred Maintenance	\$ 1,427		1
4   May and Settlement         (1,5,000)         21         4           6   Overlant Bank Charges         (4,482)         21         5           7   See	2	Prior Period Medical Supplies	(4,662)		2
50 Octamat Patanic Changes         (4,482)         21         5           6         Image: Changes         (4,482)         21         5           7         Image: Changes         (4,482)         21         7           8         Image: Changes         (4,482)         29         9           9         Image: Changes         (4,482)         9         9           10         Image: Changes         (4,482)         9         11           11         Image: Changes         (4,482)         11         11           12         Image: Changes         (4,482)         11         11           13         Image: Changes         (4,482)         11         11           14         Image: Changes         (4,482)         11         11           15         Image: Changes         (4,482)         11         11         11           15         Image: Changes         (4,482)         11         11         11         11         11         11         11         11         11         11         12         12         12         12         12         12         12         12         12         12         12         12         12		Prior Period Legal	(17,4/1)		
6         6         7         8         8         8         8         8         9         9         10         10         9         9         10         10         10         10         10         11		Consider & Book Channel	(135,000)	21	
7         8         8         8         8         9         11         11         12         11         11         12         13         13         13         14         13         14         15         15         15         15         15         15         15         15         15         15         15         16         17		Overdraft Bank Charges	(4,462)	- 21	
8         8         8         9         10         10         9         19         10         10         10         10         10         11         12         12         12         12         12         12         12         12         12         12         12         12         12         12         12         12	- 7				- 7
9         9         9         11         11         11         11         11         11         12         11         12         13         13         13         13         13         13         13         14         15         15         15         15         15         15         15         15         15         15         15         15         15         16         17         18         18         19         19         10         10         12         20         20         20         22         22         22         22         22         22         22         22         22         22         22         22         22         22         22         22         22         22         23 <td>0</td> <td></td> <td></td> <td></td> <td>0</td>	0				0
19	8				8
111         1					
12	10				10
131         131         131         151         151         151         151         151         151         151         151         151         151         151         151         151         151         171         171         172 <td>11</td> <td></td> <td></td> <td></td> <td>11</td>	11				11
14         14         15         15         16         16         16         16         16         16         17         18         16         18         18         19         18         19         12<					
15         16         16         16         16         17         17         17         17         17         17         18         19         17         19         12<					
16         16         17           18         18         18           19         19         19           20         20         22           21         22         22           22         23         24           25         26         26         26           27         27         27           28         28         29           30         29         39           31         22         30           32         30         31           32         30         31           33         34         33           34         33         34           35         36         35           36         37         33           37         38         39           38         39         39           40         40         40           41         40         40           42         42         42           43         43         44           44         44         44           45         46         46           47         48					14
17           18         18           19         19           20         10           21         21           22         22           23         23           24         25           25         26           27         25           28         27           29         27           30         30           31         30           32         30           32         33           33         34           34         34           35         35           36         34           37         36           38         34           39         39           40         30           38         39           40         30           38         39           41         42           42         43           43         44           44         42           45         44           46         47           47         48           49         49	15				15
18           18           19           19           20           20           21           20           22           23           23           23           25           26           27           27           28           27           29           29           30           30           31           31           32           31           33           34           34           31           35           30           34           31           35           31           36           31           37           33           38           30           37           35           38           30           39           40           40           40           41           40           42           40           43           40           44           40           45           40           47           40           48           40           49           40           41	16				16
19					
201         30           212         21           223         22           234         22           246         22           25         26           26         26           27         27           28         29           30         30           31         31           32         32           33         33           34         33           35         35           36         35           37         35           38         38           39         39           40         40           41         42           42         42           43         42           44         42           44         44           44         44           44         44           44         44           44         46           47         47           48         40           49         40           40         44           44         45           45					
212         22           223         23           24         23           25         25           26         27           27         27           28         29           29         30           30         30           31         30           32         33           33         34           34         34           35         36           37         37           38         30           39         39           40         40           41         41           42         42           43         43           44         42           44         42           45         40           44         42           45         40           47         42           48         40           49         40           41         41           42         43           43         44           44         42           45         44           46	19				19
22         23           23         24           24         24           25         26           26         27           28         28           29         29           30         30           31         31           32         32           33         33           34         34           35         35           36         36           37         38           39         39           40         40           41         42           42         43           43         44           44         44           45         46           46         46           47         48           49         49           90         49           91         49           92         44           44         46           47         47           48         40           90         40           91         49           92         55           55         <	20				20
33           24           25           26           27           28           29           30           31           32           33           34           35           36           37           38           39           30           31           32           33           34           35           36           37           38           39           40           41           42           43           44           42           43           44           42           43           44           44           42           43           44           42           43           44           45           46           47           48           49           9           10	21				21
23         23           24         24           25         26           26         26           27         27           28         28           29         29           30         29           31         32           32         33           33         34           34         35           36         35           36         35           37         36           38         39           40         40           41         41           42         42           43         43           44         44           42         44           44         44           44         44           45         46           46         47           47         48           49         49           51         51           52         51           53         53           54         54           46         42           47         43           48         <	22				22
24         25           26         25           26         26           27         28           29         39           30         31           31         31           32         32           33         33           34         33           35         36           37         37           38         38           39         40           41         41           42         42           43         43           44         44           45         46           46         46           47         47           48         49           90         49           91         49           92         40           93         40           44         44           45         46           47         47           48         40           49         40           51         51           52         53           53         54           54         <	23				23
25         25           26         126           27         27           28         28           29         29           30         30           31         31           32         33           33         34           35         36           36         36           37         37           38         38           39         38           40         41           41         41           42         43           43         44           44         44           44         44           44         44           44         44           44         44           44         44           45         46           47         47           48         48           49         49           51         51           52         52           53         53           54         54           46         49           50         60           61	24				24
26         26           27         27           28         28           29         30           30         31           31         31           32         33           33         34           35         35           36         36           37         37           38         38           39         39           40         40           41         41           42         41           43         44           44         44           45         46           46         47           48         48           49         49           50         50           51         50           52         50           53         53           54         48           49         40           50         50           51         50           52         50           53         53           54         60           60         60           70         <	25		İ		25
27           28           29           30           31           32           33           34           35           36           37           38           39           40           41           42           43           44           42           43           44           44           44           45           46           47           48           49           50           51           52           53           54           45           46           47           48           49           50           51           52           53           54           55           55           56           57           58           59           60           61           62			İ		
38         28           39         39           31         32           32         33           33         34           35         35           36         36           37         37           38         38           39         40           41         41           42         41           43         44           44         44           45         46           47         46           47         47           48         48           49         49           50         52           51         51           52         52           53         52           54         52           55         56           57         57           58         6           60         60           61         60           62         60           63         60           75         75           58         60           70         76           66 <t< td=""><td></td><td></td><td>İ</td><td></td><td></td></t<>			İ		
29         30         39         39         30         30         31         31         31         32         33         33         33         34         34         34         36         35         36         35         36         35         36         37         37         37         37         38         38         38         38         38         38         38         38         39         40         40         40         41         41         41         41         41         42         42         42         42         42         42         42         43         44<					
30         30           31         31           32         32           33         33           34         36           35         36           37         37           38         38           39         40           41         41           42         42           43         44           44         44           45         46           47         47           48         48           49         48           49         48           49         48           49         48           49         48           49         48           40         48           47         51           51         51           51         51           52         52           53         54           54         54           55         56           57         57           58         6           60         6           61         6           62	29				29
31         31           32         32           33         34           34         36           35         36           36         37           38         38           39         39           40         40           41         41           42         42           43         43           44         44           45         44           46         44           47         46           47         47           48         49           50         50           51         51           52         52           53         53           54         54           45         54           46         49           47         40           48         40           49         40           50         55           51         51           52         52           53         53           54         54           55         55           57         <	30				30
32   33   33   33   33   33   34   34					
33   34   34   34   34   35   35   35				l	22
34         34           35         35           36         36           37         38           39         39           40         40           41         41           42         41           43         43           44         43           45         46           47         47           48         49           49         49           50         51           51         52           52         40           53         53           54         40           55         56           66         60           57         55           58         90           61         60           57         57           62         60           63         60           64         60           65         60           66         60           67         60           68         60           69         60           61         60           62         <				-	
35         36         35           37         37         37           38         38         38           39         40         40         40           41         41         41         41           42         42         43         43           44         44         44         44           45         46         46         46           47         47         48         49           49         49         48         49           50         51         51         51           51         51         51         51           52         52         53         53           54         54         54         55           55         55         56         56           61         60         60         60           62         60         60         60           61         62         62         62           62         63         64         64           65         66         66         66           67         66         66         66           67 </td <td></td> <td></td> <td>-</td> <td>l</td> <td></td>			-	l	
36         36           37         38           38         39           40         39           40         40           41         41           42         42           43         44           45         45           46         45           47         47           48         48           49         49           50         49           51         51           52         52           53         53           54         54           55         55           56         55           57         55           58         9           60         60           61         60           77         57           78         70           79         70           70         70           70         70           70         70           70         70           70         70           70         70           70         70           70 <t< td=""><td>34</td><td></td><td></td><td>-</td><td>34 2F</td></t<>	34			-	34 2F
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38         38           39         39           40         40           41         41           42         42           43         44           45         45           46         46           47         47           48         48           49         49           50         50           51         51           52         51           53         54           54         55           55         50           57         55           58         9           60         60           61         60           77         57           88         9           89         6           61         60           62         6           63         6           64         6           65         7           80         7           81         8           82         8           83         8           84         8           85         8	36				36
39   9   9   9   9   9   9   9   9   9					
40   40   41   42   42   43   44   45   46   46   46   46   46   46					
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42   43   44   45   46   47   46   47   47   48   48   49   49   49   49   49   49	40				40
43   44   45   44   46   47   46   46   47   47   48   49   48   49   49   49   49   49					
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45   45   46   46   46   47   47   48   48   48   48   48   48	43				43
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47   47   48   48   48   48   48   48	45				45
48   48   48   48   49   49   49   49					
48   48   48   48   49   49   49   49	47				47
59         59           51         51           52         52           53         32           54         53           55         55           56         56           57         57           58         88           59         60           61         61           62         61           63         64           64         63           65         65           66         66           67         65           68         66           67         67           68         69           70         77           71         72           72         73           73         74           74         75           76         76           77         77           78         78           79         78           81         80           82         82           83         84           84         84           85         86           86         <	48				48
51         51         51         52         52         53         53         53         53         53         54         54         54         55         56         56         56         56         56         57         57         57         57         58         58         58         58         58         58         58         59         60<	49				49
\$2   \$3   \$3   \$3   \$4   \$5   \$5   \$5   \$5   \$5   \$5   \$5	50				50
\$2   \$3   \$3   \$3   \$4   \$5   \$5   \$5   \$5   \$5   \$5   \$5	51				51
\$3   \$3   \$4   \$5   \$5   \$5   \$5   \$5   \$5   \$5	52				52
54         54           55         5           56         5           57         7           58         8           59         6           60         60           61         61           62         62           63         63           64         64           65         65           66         66           67         67           68         69           70         70           71         71           72         72           73         73           74         73           75         76           77         77           78         77           79         77           79         77           79         77           79         77           79         77           80         80           81         81           82         82           83         84           84         84           85         86           87         88	53				53
56         56           57         57           58         58           59         99           60         99           61         60           62         62           63         63           64         64           65         65           66         66           67         67           68         68           69         70           70         70           71         71           72         72           73         73           74         74           75         75           76         77           77         77           78         77           79         77           80         80           81         80           82         82           83         84           84         84           85         86           86         86					
56         56           57         57           58         58           59         99           60         99           61         60           62         62           63         63           64         64           65         65           66         66           67         67           68         68           69         70           70         70           71         71           72         72           73         73           74         74           75         75           76         77           77         77           78         77           79         77           80         80           81         80           82         82           83         84           84         84           85         86           86         86	55				55
57   58   58   58   58   59   59   59   59	56				56
\$8   \$8   \$8   \$9   \$9   \$9   \$9   \$9	57				57
59         9           61         60           62         62           63         63           64         64           65         65           66         67           67         67           68         68           69         70           71         71           72         72           73         72           74         74           75         75           76         76           77         78           78         78           79         78           81         81           82         82           83         84           84         84           85         84           86         85           87         87           88         88	58				58
60   60   60   60   61   62   62   62   63   64   64   65   65   66   66   66   66					
61 62 63 64 64 65 66 66 67 67 68 68 69 69 69 79 79 79 79 79 79 79 79 79 79 79 79 79				l	
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65   65   66   66   66   66   66   66				l	
66         66           67         67           68         68           69         68           70         70           71         72           72         72           73         73           74         74           75         75           76         76           77         77           78         78           79         79           80         79           81         83           82         83           84         84           85         85           86         85           87         88           88         88           89         88				l	
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68 69 69 69 69 69 69 69 69 69 69 69 69 69	67			-	67
69	60			-	69
79			-	l	
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80 90 90 90 90 90 90 90 90 90 90 90 90 90					
81         S1           82         S2 S2           83         S3           84         S5           85         S5           86         S6           87         S7           88         S8           89         S9					
82 82 82 82 82 83 83 83 84 84 84 85 85 85 85 85 85 87 87 88 88 88 88 88 88 88 88 89 89 89 89 89	80				80
\$3   \$3   \$3   \$4   \$4   \$4   \$4   \$4	81				81
84 85 85 85 85 86 87 87 87 87 88 88 88 88 88 88 88 88 88	82				82
85 85 85 85 85 85 85 85 85 85 85 85 85 8					
86         86           87         87           88         88           89         89					
86         86           87         87           88         88           89         89	85				85
87 87 87 87 88 88 88 88 88 89 89	86				86
88 89 89 89	87				87
89	88				88
90 Total (160,188) 90					89
		Total	(160,188)		90

STATE OF ILLINOIS Summary A Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTER, # 0041210 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 61

	SUMMARY OF PAGES 5, 5A, 0, 0A	2,02,00,02,	02, 01, 00, 0										SUMMARY	
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6Н	61	(to Sch V, col	.7)
1	Dietary		-	-	-		-	-					1	1
2	Food Purchase	(85)											(85)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	1,427											1,427	6
7	Other (specify):*													7
8	TOTAL General Services	1,342											1,342	8
	B. Health Care and Programs													
9	Medical Director												1	9
10	Nursing and Medical Records	(4,662)		11,795									7,133	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
	Program Transportation													14
15	Other (specify):*			1,368									1,368	15
16	TOTAL Health Care and Programs	(4,662)		13,163									8,501	16
	C. General Administration													
17				(119,205)									(119,205)	17
18	Directors Fees													18
19	Professional Services	(17,471)		4,988									(12,483)	
20	Fees, Subscriptions & Promotions	(4,099)		348									(3,751)	20
21	Clerical & General Office Expenses	(148,608)		53,758									(94,850)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24				247									247	24
25	Other Admin. Staff Transportation			4,065									4,065	
26	Insurance-Prop.Liab.Malpractice			695			-						695	
27	Other (specify):*			8,884									8,884	27
28	TOTAL General Administration	(170,178)		(46,220)									(216,398)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(173,498)		(33,057)									(206,555)	29

STATE OF ILLINOIS Summary B ELMWOOD NURSING & REHABILITATION CENTER, # 0041210 Report Period Beginning: 01/01/00 Ending: 12/31/00 Facility Name & ID Number

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	<b>6E</b>	6F	6 <b>G</b>	6Н	<b>6</b> I	(to Sch V, col.	.7)
30	Depreciation	345	61,823	948									63,116	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(13,433)	154,644	42									141,253	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(380,640)	5,831									(374,809)	34
35	Rent-Equipment & Vehicles			6,338									6,338	35
36	Other (specify):*													36
37	TOTAL Ownership	(13,088)	(164,173)	13,159									(164,102)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
	GRAND TOTAL COST	ĺ												
45	(sum of lines 29, 37 & 44)	(186,586)	(164,173)	(19,898)									(370,657)	45

12/31/00

#### VII. RELATED PARTIES

Facility Name & ID Number

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1		2			3			
OWNERS		RELATED NURSIN	OTHER RE	OTHER RELATED BUSINESS ENTITIES				
Name Ownership %		Name City		Name	Name City			
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED				
				MARYVILLE HEA	LTH			
				PROPERTIES	MARYVILLE	BUILDING CO		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization		7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sc	nedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
					0		Organization	Costs (7 minus 4)	
1	V	34	RENTAL INCOME	\$ 380,640	MARYVILLE HEALTH PROPERTIES	100.00%	\$	\$ (380,640)	1
2	V		DEPRECIATION		MARYVILLE HEALTH PROPERTIES	100.00%	61,823	61,823	2
3	V	32	INTEREST EXP-MORTGAGE		MARYVILLE HEALTH PROPERTIES	100.00%	154,644	154,644	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 380,640			\$ 216,467	§ * (164,173)	14

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

#### VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, X YES NO management fees, purchase of supplies, and so forth.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
						Percent	Operating Cost	Adjustments for
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization
						Ownership	Organization	Costs (7 minus 4)
15	V	17	ADMIN. SALNON OWNER	\$	HEALTHCARE MNGMNT, ASSOC.	100.00%	\$ 18,037	
16	V	19	PROFESSIONAL FEES		HEALTHCARE MNGMNT, ASSOC.	100.00%	4,988	4,988 16
17	V	20	DUES, SUBSCRIPTIONS		HEALTHCARE MNGMNT, ASSOC.	100.00%	348	348 17
18	V	21	CLERICAL & GENERAL		HEALTHCARE MNGMNT, ASSOC.	100.00%	33,753	33,753 18
19	V	24	SEMINAR		HEALTHCARE MNGMNT. ASSOC.	100.00%	247	247 19
20	V	25	TRAVEL		HEALTHCARE MNGMNT, ASSOC.	100.00%	4,065	4,065 20
21	V	26	INSURANCE		HEALTHCARE MNGMNT. ASSOC.	100.00%	695	695 21
22	V	27	EMPLOYEE BENEFITS		HEALTHCARE MNGMNT, ASSOC.	100.00%	4,900	4,900 22
23	V		DEPRECIATION		HEALTHCARE MNGMNT. ASSOC.	100.00%	948	948 23
24	V	34	OFFICE SPACE		HEALTHCARE MNGMNT. ASSOC.	100.00%	5,831	5,831 24
25	V		INTEREST		HEALTHCARE MNGMNT, ASSOC.	100.00%	42	42 25
26	V	35	EQUIPMENT RENTAL		HEALTHCARE MNGMNT. ASSOC.	100.00%	6,338	6,338 26
27	V	10	NURSING SALARIES		HEALTHCARE MNGMNT. ASSOC.	100.00%	11,795	11,795 27
28	V	15	EMP. BEN HEALTH CARE		HEALTHCARE MNGMNT, ASSOC.	100.00%	1,368	1,368 28
29	V	21	CLERICAL SALARIES		HEALTHCARE MNGMNT. ASSOC.	100.00%	20,005	20,005   29
30	V	27	EMP. BEN. GEN. & ADMIN.		HEALTHCARE MNGMNT. ASSOC.	100.00%	2,353	2,353 30
31	V							31
32	V	17	ADMIN. SALARY - M. SUISSA		HEALTHCARE MNGMNT. ASSOC.	100.00%	3,964	3,964   32
33	V	17	ADMIN. SALARY - D. ARYEH		HEALTHCARE MNGMNT. ASSOC.	100.00%	8,794	8,794   33
34	V	27	EMP. BENM. SUISSA		HEALTHCARE MNGMNT, ASSOC.	100.00%	554	554 34
35	V	27	EMP. BEND. ARYEH		HEALTHCARE MNGMNT. ASSOC.	100.00%	1,077	1,077 35
36	V							36
37	V	17	MANAGEMENT FEE	150,000	HEALTHCARE MNGMNT, ASSOC.	100.00%		(150,000) 37
38	V							38
39	Total			\$ 150,000			\$ 130,102	\$ * (19,898) 39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

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Page 6B ELMWOOD NURSING & REHABILITATION CENTER, LLC Ending: 12/31/00 Facility Name & ID Number 0041210 **Report Period Beginning:** 01/01/00

# VII. RELATED PARTIES (continued)

B.	Are any costs included in this report which are a result of transactions with related organizations? This includes rent,											
	management fees, purchase of supplies, and so forth.		YES		NO							
	TC				1 44							

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	n
					· ·	Ownership	Organization	Costs (7 minus 4)	
15	V							\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	s *	39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

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Page 6C ELMWOOD NURSING & REHABILITATION CENTER, LLC # 0041210 Report Period Beginning: Ending: 12/31/00 Facility Name & ID Number 01/01/00

# VII. RELATED PARTIES (continued)

B.	3. Are any costs included in this report which are a result of transactions with related organizations? This includes rent,										
	management fees, purchase of supplies, and so forth.		YES		NO						
	If we costs incurred as a result of transactions with related organizations must be fully itemized in accordance with										

	the instru	ctions f	or determining costs as specified for	this form.	•				
	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sche	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
John		Zine		1	Tume of recined organization	Ownership	Organization	Costs (7 minus 4)	
15	V					Ownership	Organization	\$ 15	_
16	v							16	
17	V							17	
18	V							18	_
19	V							19	
20	V							20	0
21	V							21	1
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V	1		1				35 36	
36	V			1					
38	V	1			<u> </u>			37	/ Q
39	Total			<b>S</b>			\$ 0	\$ * 39	9

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

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Page 6D ELMWOOD NURSING & REHABILITATION CENTER, LLC # 0041210 Report Period Beginning: Ending: 12/31/00 Facility Name & ID Number 01/01/00

# VII. RELATED PARTIES (continued)

B.	Are any costs included in this report which are a result of transactions wi	th rel	ated organizat	ions?	This includes rent,					
	management fees, purchase of supplies, and so forth.		YES		NO					
	If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with									

	the instru	ctions f	or determining costs as specified for	this form.					
	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sche	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	1
						Ownership	Organization	Costs (7 minus 4)	
15	V			s		отпетьтр	\$	s	15
16	V			-	-		*	-	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
30	V		<u> </u>						30
31	V								31
32	V		<u> </u>						32
33	V								33
34	v								34
35	v								35
36	V								36
37	V				-				37
38	V								38
39	Total			s			s 0	s *	39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

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Page 6E ELMWOOD NURSING & REHABILITATION CENTER, LLC # 0041210 Report Period Beginning: Ending: 12/31/00 Facility Name & ID Number 01/01/00

# VII. RELATED PARTIES (continued)

B.	Are any costs included in this report which are a result of transactions wi		
	management fees, purchase of supplies, and so forth.	YES	NO
	If was access in anymoid as a mosule of transactions with valeted amountation	 4 h a faller itami	 

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
			_			Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	n
						Ownership	Organization	Costs (7 minus 4)	
15	V			s		оастанър	\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	<u> </u>								35
36	V								36
37	V								37
38									38
39	Total			\$			\$ 0	s *	39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

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Page 6F Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTER, LLC 0041210 **Report Period Beginning:** 01/01/00 12/31/00 Ending:

#### VII. RELATED PARTIES (continued)

36

37

39 Total

V

V

B.	Are any costs included in this report which are a result of transactions wi	th rel	ated organizat	ions?	This includes rent,
	management fees, purchase of supplies, and so forth.		YES		NO
	If yes, costs incurred as a result of transactions with related organizations	mus	t be fully itemi	zed ir	accordance with

the instructions for determining costs as specified for this form. 3 Cost Per General Ledger 5 Cost to Related Organization 8 Difference: **Operating Cost** Adjustments for Percent Schedule V Line Name of Related Organization of Related **Related Organization** Item Amount of Ownership Organization Costs (7 minus 4) 15 15 16 16 17 17 V 18 V 18 19 V 19 V 20 20 21 V 21 22 23 24 V 22 23 V V 24 25 26 27 V 25 V 26 V 27 28 29 V 28 V 29 30 V 30 31 V 31 32 V 32 33 V 33 34 35 V 34

35

36

37 38

39

0 \$ \*

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

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Page 6G Ending: 12/31/00 ELMWOOD NURSING & REHABILITATION CENTER, LLC # 0041210 Report Period Beginning: Facility Name & ID Number 01/01/00

'II. RELATED PARTIES (c	continued)
-------------------------	------------

B.	Are any costs included in this report which are a result of transactions with related organizations? This includes rent,
	management fees, purchase of supplies, and so forth.  YES  NO
	If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

th	instruc	ctions fo	or determining costs as specified for	this form.	•				
1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		•				Percent	Operating Cost	Adjustments for	
Schedu	ule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
					- ········	Ownership	Organization	Costs (7 minus 4)	
15	V			s		Ownership	\$	s	15
16	v			•			Ψ		16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								33
33	V								34
35	V								35
36	V								36
37	V								37
38	V								38
	,			0			<b>6</b> 0	e *	
39 T	otal			3			[S 0	s *	39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

ST.	ATE	OF	ш	INOL	C

Page 6H ELMWOOD NURSING & REHABILITATION CENTER, LLC # 0041210 Report Period Beginning: Ending: 12/31/00 Facility Name & ID Number 01/01/00

ZΠ	REI	ATED	PARTIES	(continued)

the instructions for determining costs as specified for this form.

В.	. Are any costs included in this report which are a result of transactions with r	elated organiza	tions?	This includes rent,									
	management fees, purchase of supplies, and so forth.												
	If yes, costs incurred as a result of transactions with related organizations mu	ıst be fully item	ized iı	accordance with									

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sche	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	n
					- · · · · · · · · · · · · · · · · · · ·	Ownership	Organization	Costs (7 minus 4)	_
15	V			s		Ownership	\$	s	15
16	v			Ψ			Ψ	<b>9</b>	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V					ļ			34
35	V								35
36	V	1							36
37	V	1							38
	•						_		
39	39 Total			18			I\$ 0	\$ *	39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

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Page 6I Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTER, LLC 0041210 Report Period Beginning: 01/01/00 Ending: 12/31/00

# VII. RELATED PARTIES (continued)

B.	B. Are any costs included in this report which are a result of transactions with related organizatio management fees, purchase of supplies, and so forth.	ns? This includes rent,
	management fees, purchase of supplies, and so forth.  YES  If yes, costs incurred as a result of transactions with related organizations must be fully itemize	

	the instru	ictions f	or determining costs as specified for	r this form.	·				
	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
					ž – – – – – – – – – – – – – – – – – – –	Percent	Operating Cost	Adjustments for	
Sch	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	n
5011	aure ,	Ziiic	10011	111104110	Tume of Related Organization	Ownership	Organization	Costs (7 minus 4)	-
15	V			\$		Ownership	© gamzation	Costs (7 minus 4)	15
16	V						J.	3	16
17	v								17
18	v								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	s *	39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7 **ELMWOOD NURSING & REHABILITAT** # 01/01/00 12/31/00 Facility Name & ID Number 0041210 **Report Period Beginning: Ending:** 

#### VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6	6	7		8	
						Average Hou	rs Per Work				
					Compensation	Week Devo	oted to this	Compensati	on Included	Schedule V.	
					Received	Facility and	% of Total	in Costs	for this	Line &	
				Ownership	From Other	Work	Week	Reportin	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	ERIC ROTHNER	OWNER	ADMINISTRATIV	52.89	SEE ATTACHED	0.4	0.01	MGT FEES	\$ 38,640	17-3	1
2	MARK SUISSA	OWNER	ADMINISTRATIV	42.31	SEE ATTACHED	5.77	0.09	MGT FEES	38,640	17-3	2
3	MARK SUISSA	OWNER	ADMINISTRATIV	42.31	SEE ATTACHED	5.77	0.09	ALLOC-HMA	3,964	17-7	3
4	DAVID ARYEH	OWNER	<b>ADMINISTRATIV</b>	4.80	SEE ATTACHED	11.17	0.16	MGT FEES	6,720	17-3	4
5	DAVID ARYEH	OWNER	ADMINISTRATIV	4.80	SEE ATTACHED	11.17	0.16	ALLOC-HMA	8,794	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 96,758		13

<sup>\*</sup> If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

<sup>\*\*</sup> This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

STATE OF ILLINOIS

Page 8 ELMWOOD NURSING & REHABILITATION CENTE # 0041210 Report Period Beginning: Facility Name & ID Number 01/01/00 Ending: 12/31/00

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	Name of Related Organization
A. Are there any costs included in this report which were derived from allocations of central office	Street Address
or parent organization costs? (See instructions.)  YES  NO X	City / State / Zip Code
<del>_</del>	Phone Number (
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number (

	ı	T	1		1		1	ı	1	
	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	Reference	Titelli .	Square reety	Total Clits	Athocated Athlong	Amocateu	in column o	Cints	(01.0/01.4)4 (01.0	1
2										2
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18										18
19										19
20										20
21										21
22										22 23
23										23
24						_			_	24
25	TOTALS					\$	\$		\$	25

STATE OF ILLINOIS Page 8A ELMWOOD NURSING & REHABILITATION CENTE # 0041210 Report Period Beginning: Facility Name & ID Number 01/01/00 Ending: 12/31/00

#### VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES X NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Street Address City / State / Zip Code Phone Number

HEALTHCARE MNGMNT. ASSOC. 1401 S. BRENTWOOD BOULEVARD

BRENTWOOD, MO. 63144

( 314) 963-7570 Fax Number ( 314) 963-9030

	1	2	3	4	5	6	7	8	9	$\prod$
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		<b>Subunits Being</b>	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	17	ADMIN. SALNON OWNER	ILL. & MO. PAT. DAYS	357,313	8	\$ 187,631	\$ 187,631	34,349	\$ 18,037	1
2	19	PROFESSIONAL FEES	ILL. & MO. PAT. DAYS	357,313	8	51,885		34,349	4,988	2
3	20	DUES, SUBSCRIPTIONS	ILL. & MO. PAT. DAYS	357,313	8	3,624		34,349	348	3
4	21	CLERICAL & GENERAL	ILL. & MO. PAT. DAYS	357,313	8	351,114	271,845	34,349	33,753	4
5	24	SEMINAR	ILL. & MO. PAT. DAYS	357,313	8	2,566		34,349	247	5
6	25	TRAVEL	ILL, & MO. PAT. DAYS	357,313	8	42,286		34,349	4,065	6
7	26	INSURANCE	ILL. & MO. PAT. DAYS	357,313	8	7,228		34,349	695	7
8	27	EMPLOYEE BENEFITS	ILL, & MO. PAT. DAYS	357,313	8	50,973		34,349	4,900	8
9	30	DEPRECIATION	ILL. & MO. PAT. DAYS	357,313	8	9,866		34,349	948	9
10	34	OFFICE SPACE	ILL. & MO. PAT. DAYS	357,313	8	60,660		34,349	5,831	10
11		INTEREST	ILL, & MO, PAT, DAYS	357,313	8	432		34,349	42	11
12	35	EQUIPMENT RENTAL	ILL. & MO. PAT. DAYS	357,313	8	65,934		34,349	6,338	12
13	10	NURSING SALARIES	ILLINOIS PAT. DAYS	221,422	5	76,034	76,034	34,349	11,795	13
14			ILLINOIS PAT. DAYS	221,422	5	8,817		34,349	1,368	14
15			ILLINOIS PAT. DAYS	221,422	5	128,960	128,960	34,349	20,005	15
16	27	EMP. BEN. GEN. & ADMIN.	ILLINOIS PAT. DAYS	221,422	5	15,168		34,349	2,353	16
17										17
18	17	ADMIN. SALARY - M. SUISSA	AVG. HOURS WORKED	60	8	41,231	41,231	6	3,964	18
19	17	ADMIN. SALARY - D. ARYEH	AVG. HOURS WORKED		5	56,690	56,690	11	8,794	19
20		EMP. BENM. SUISSA	AVG. HOURS WORKED		8	5,760		6	554	20
21	27	EMP. BEND. ARYEH	AVG. HOURS WORKED	72	5	6,943		11	1,077	21
22										22
23		_								23
24										24
25	TOTALS					\$ 1,173,802	\$ 762,391		\$ 130,102	25

STATE OF ILLINOIS Page 8B ELMWOOD NURSING & REHABILITATION CENTE # 0041210 Report Period Beginning: 01/01/00 Facility Name & ID Number Ending: 12/31/00

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III. RELOCATION OF INDIRECT COSTS		
	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.)	City / State / Zip Code	
<del></del>	Phone Number	( )
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	( )

	1	2	3	4	5	6	7	8	9	T
	Schedule V	2	Unit of Allocation	7	Number of	Total Indirect	Amount of Salary	0	,	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
		<b>.</b> .		TD 4 1 TT 14						
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	2		\$	1
2										2
3										3
4										4
5										5
6										6
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

STATE OF ILLINOIS Page 8C ELMWOOD NURSING & REHABILITATION CENTE # 0041210 Report Period Beginning: 01/01/00 Facility Name & ID Number Ending: 12/31/00

			~	~ ~ ~ ~ ~
$\mathbf{v}$	$\Delta$ I I	OCATION	OF INDIRECT	COSTS

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.)  YES NO	City / State / Zip Code	
<del></del>	Phone Number	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	( )

	1	2	3	4	5	6	7	8	9	$\top$
	Schedule V	2	Unit of Allocation	•	Number of	Total Indirect	Amount of Salary	0	,	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	Reference	Tem .	Square recty	Total Clits		S	\$	Circs	\$	1
2						•	Ψ		•	2
3										3
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16 17										16 17
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	TOTALS					S	s		S	25

STATE OF ILLINOIS Page 8D Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTE # 0041210 Report Period Beginning: 01/01/00 Ending: 12/31/00

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	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.)  YES NO	City / State / Zip Code	
	Phone Number	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	( )

									<del>-</del>	
	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			•			\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
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24										24
	TOTAL						Φ.		0	24
25	TOTALS					\$	\$		[\$	25

STATE OF ILLINOIS Page 8E ELMWOOD NURSING & REHABILITATION CENTE # 0041210 Report Period Beginning: 01/01/00 Facility Name & ID Number Ending: 12/31/00

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	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.)  YES  NO	City / State / Zip Code	
<del></del>	Phone Number	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	

	1	2	3	4	5	6	7	8	9	T
	Schedule V	2	Unit of Allocation	7	Number of	Total Indirect	Amount of Salary	0	,	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
		<b>.</b> .		TD 4 1 TT 14						
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	2		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
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21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

City / State / Zip Code

Ending: 12/31/00

STATE OF ILLINOIS Page 8F Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTE # 0041210 Report Period Beginning: 01/01/00

VIII. ALLOCATION OF INDIRECT COSTS	
	Name of Related Organization
A. Are there any costs included in this report which were derived from allocations of central office	Street Address

Phone Number B. Show the allocation of costs below. If necessary, please attach worksheets. Fax Number

NO

YES

or parent organization costs? (See instructions.)

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			1			\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
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17										17
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					S	\$		\$	25

STATE OF ILLINOIS Page 8G ELMWOOD NURSING & REHABILITATION CENTE # 0041210 Report Period Beginning: 01/01/00 Facility Name & ID Number Ending: 12/31/00

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	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.)  YES NO	City / State / Zip Code	
<del></del>	Phone Number	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	( )

	1	2	3	4	5	6	7	8	9	T
	Schedule V	2	Unit of Allocation	7	Number of	Total Indirect	Amount of Salary	0	,	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
		<b>.</b> .		TD 4 1 TT 14						
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	2		\$	1
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3										3
4										4
5										5
6										6
7										7
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21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

STATE OF ILLINOIS Page 8H Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTE # 0041210 Report Period Beginning: 01/01/00 Ending: 12/31/00

۲	71	n	n	ſ	٨	T	1	r	n		۸	п	ΓÌ	ī	n	T	J	•	n	L	7	П	N	T	١.	П	D	L	١,	r	г	~	O	•	ריב	Г	ž

	Name of Related Organization		
A. Are there any costs included in this report which were derived from allocations of central office	Street Address		
or parent organization costs? (See instructions.) YES NO	City / State / Zip Code		
<del></del>	Phone Number	( )	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	( )	

	1	2	3	4	5	6	7	8	9	T
	Schedule V	2	Unit of Allocation	7	Number of	Total Indirect	Amount of Salary	0	,	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
		<b>.</b> .		TD 4 1 TT 14						
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	2		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

STATE OF ILLINOIS Page 8I ELMWOOD NURSING & REHABILITATION CENTE # 0041210 Report Period Beginning: 01/01/00 Facility Name & ID Number Ending: 12/31/00

۲	71	n	n	ſ	1	ı	r	T	O	1	$\overline{}$	۸	7	r	1	ጎ	N	J	ſ	ì	F	T	N	П	٦	T	D	L	١,	C	г	~	n	c	ריב	Г	2

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.)  YES  NO	City / State / Zip Code	
<del>_</del>	Phone Number	( )
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	( )

	1	2	3	4	5	6	7	8	9	T
	Schedule V	2	Unit of Allocation	7	Number of	Total Indirect	Amount of Salary	0	,	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
		<b>.</b> .		TD 4 1 TT 14						
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	2		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

#### IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5		6	7	8	9	10	
	Name of Lender	Relate		Purpose of Loan	Monthly Payment	Date of			int of Note	Maturity Date	Interest Rate	Reporting Period Interest	
	A. Dina alla Espilla Delea d	YES	NO		Required	Note		Original	Balance		(4 Digits)	Expense	
	A. Directly Facility Related												
1	Long-Term CORUS BANK		X	MORTGAGE	\$20,611.00	10/01/05	s	1,833,000	0 1 (21 172	10/01/10	10.0000 \$	154 (44	1
1	CURUS BANK	-	Λ	MURIGAGE	\$20,011.00	10/01/95	Э	1,833,000	\$ 1,631,172	10/01/10	10.0000 \$	154,644	2
3													3
4		-					1						1
5		+ +											5
3	Working Capital												
6	,, or any cupitar		X	LINE OF CREDIT					200,000		10.5000	20,742	6
7	DUE TO GRAND MANOR	X							,			242	7
8													8
9	TOTAL Facility Related				\$20,611.00		\$	1,833,000	\$ 1,831,172		S	175,628	9
	B. Non-Facility Related*												
	Supplemental Schedule												10
	FINANCE CHARGES		X									12,225	11
12	INTEREST INCOME		X									(13,433)	12
13	ALLOC-HMA		X	_				·				42	13
14	TOTAL Non-Facility Related						\$		\$		\$	(1,166)	14
													1
15	TOTALS (line 9+line14)				- 11 1		\$	1,833,000	\$ 1,831,172		\$	174,462	15

<sup>\*</sup> Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

<sup>\*\*</sup> If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ELMWOOD NURSING & REHABILITATION

# 0041210

Report Period Beginning:

01/01/00

Ending:

12/31/00

#### IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6	7	8	9	10	
										Reporting	
				Monthly				Maturity	Interest	Period	
	Name of Lender	Related**	Purpose of Loan	Payment	Date of	Amou	ant of Note	Date	Rate	Interest	
		YES NO		Required	Note	Original	Balance		(4 Digits)	Expense	
1						\$	\$			\$	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20					_						20
21						\$	\$			\$	21

STATE OF ILLINOIS

Page 10 Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTER, LLC 12/31/00 # 0041210 Report Period Beginning: 01/01/00 Ending:

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

**B.** Real Estate Taxes

1. Real Estate Tax accrual used on 1999 repo	rt.			\$	36,000	1
2. Real Estate Taxes paid during the year: (In	dicate the tax year to which this payment applies. If payment cover	rs more than one year, d	etail below.)	\$	36,766	2
3. Under or (over) accrual (line 2 minus line	1).			\$	766	3
4. Real Estate Tax accrual used for 2000 repo	ort. (Detail and explain your calculation of this accrual on the lines	below.)		\$	38,000	4
11	ts which has NOT been included in professional fees or other generated copies of invoices to support the cost and a copies of invoices the cost and a copies of invoices to support the cost and a copies of invoices of the cost and a copies of the cost and a copies of the cost and a copies of the cost and a copies of the cost and a copies of the cost and a copies of the cost and a copies of the copies of the cost and a copies of the cost and a copies of the copies of t			\$		5
amount of any direct appeal costs classified	previously to calculate a payment rate. You must offset the full d as a real estate tax cost plus one-half of any remaining refund.  For 19 Tax Year. (Attach a copy of the real)	I estate tax appeal	board's decision.)	\$		
7. Real Estate Tax expense reported on Scheo	dule V, line 33. This should be a combination of lines 3 thru 6			\$	38,766	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	1995 32,234 8		FOR OHF USE ONLY			
	1996 33,873 9					
	1997 34,833 10	13	FROM R. E. TAX STATEMENT I	FOR 1999 \$		1
	1997 34,833 10 1998 35,630 11 1999 36,766 12	13	FROM R. E. TAX STATEMENT I	·		
1999 TAX * 103% (ESTIMATED INCREASE	1998 35,630 11 1999 36,766 12			·		1:

NOTES:

- 1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
- 2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.

  This denial must be no more than four years old at the time the cost report is filed.

			VTER, LLC			g: 01/01/00 Ending:	Page 11 12/31/00				
A.	Square Feet: 26,695	B. General Construction Type:	Exterior	BRICK	Frame WOOD	Number of Stories	2				
C.	Does the Operating Entity?	(c) Rent from Completely Unrelated									
	(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)										
D.											
	(Facilities checking (a) or (b) must c	omplete Schedule XI-C. Those checking	(c) may complete Sche	edule XI-C or Schedul	e XII-B. See instructions.)	Omerated Organization.					
Е.	(such as, but not limited to, apartme	nts, assisted living facilities, day training	g facilities, day care, in	dependent living facil							
	NONE										
F.	Does this cost report reflect any org: If so, please complete the following:	anization or pre-operating costs which a	re being amortized?		YES	X NO					
1.	Total Amount Incurred:	me & ID Number ELMWOOD NURSING & REHABILITATION CENTER, LLC # 0041210 Report Period Beginning: 01/01/00 Ending: 12/31/00 NIGAND GENERAL INFORMATION:  are Feet: 26,695 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 2  s the Operating Entity? (a) Own the Facility X (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.  s the Operating Entity? (a) Own the Equipment X (b) Rent equipment from a Related Organization.  s the Operating Entity? (a) Own the Equipment X (b) Rent equipment from a Related Organization.  S the Operating Entity? (a) Own the Equipment X (b) Rent equipment from a Related Organization.  S the Operating Entity? (a) Own the Equipment X (b) Rent equipment from a Related Organization.  S the Operating Entity? (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)  all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds has, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) entity name, type of business, square footage, and number of beds/units available (where applicable).  S this cost report reflect any organization or pre-operating costs which are being amortized?  S this cost report reflect any organization or pre-operating costs which are being amortized?  S this cost report reflect any organization or pre-operating costs which are being amortized?  S this cost report reflect any organization or pre-operating costs which are being amortized?  S this cost report reflect any organization or pre-operating costs which are being amortized?  S this cost report reflect any organization or pre-operating costs which are being amortized?  S this cost report reflect any organization or pre-operating costs which are being amortized?  S the Operating Entity?  S the Operating En									
3.	(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)  E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day care, independent living facilities, nurse aide training facilities, etc.)  List entity name, type of business, square footage, and number of beds/units available (where applicable).  NONE  F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  If so, please complete the following:  1. Total Amount Incurred:  2. Number of Years Over Which it is Being Amortized:  3. Current Period Amortization:  4. Dates Incurred:  Nature of Costs:										
If so, please complete the following:  1. Total Amount Incurred:  2. Number of Years Over Which it is Being Amortized:  3. Current Period Amortization:  4. Dates Incurred:  Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)											
XI. O	WNERSHIP COSTS:		_								
	A. Land.	1 Use	Square Feet	Year Acquired	4 Cost 95 \$ 184,895						

184,895

2 3 TOTALS STATE OF ILLINOIS

Page 12 12/31/00 Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTER, LLC # 0041
XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0041210 **Report Period Beginning:** 01/01/00 Ending:

	D. Dullul	ng Depreciation-Including Fixed Equ	npment. (See instr	uctions.) Round	ı an nu	impers to nea	rest donar.				9	
	1	FOR OHE LICE ONLY	Z Z	3		4	3	6	64 141:	8	,	
		FOR OHF USE ONLY	Year	Year			Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed		Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	104		1995	1969	\$	1,698,088	\$ 43,541	35	\$ 48,517	\$ 4,976	\$ 254,714	4
5												5
6												6
7												7
8												8
	Impro	vement Type**	•									
9	HOT WATE	CR REPAÍŘS		1996		1,190	31	20	60	29	280	9
10	HOT TUB			1996		2,376	61	20	119	58	555	10
11	REPAIRS			1996		2,622	67	20	131	64	579	11
12	WALK IN C	COOLER		1996		648	17	20	32	15	144	12
13	EXHAUST	FAN INSTALL		1996		1,507	39	20	75	36	350	13
	AIR COND.			1996		14,650	376	20	733	357	3,421	14
15	PAINT & D	ECORATING		1996		14,600		20	730	730	2,920	15
16	CARPET			1996		625	16	20	31	15	142	16
17		AIN CABINET		1996		1,161	30	20	58	28	256	17
_		SOR REPAIRS		1996		3,588	92	20	179	87	791	18
	LAMP LEN			1996		691	18	20	35	17	155	19
		SYST. TANK		1996		1,023	26	20	51	25	242	20
	LIGHT FIX			1996		1,115	29	20	56	27	243	21
		T TROFFER		1996		638	16	20	32	16	147	22
	REPAIR PU	MP		1996		985	25	20	49	24	212	23
24												24
25												25
26												26
27												27
28												28
29												29
30		·				·						30
31		·				·						31
32		·				·						32
33		·										33
	PAGE 12B T					60,567	6,384		2,296	(4,088)	2,645	34
	PAGE 12A					98,237	2,437		4,912	2,475	15,469	35
36	TOTAL (line	es 4 thru 35)			\$	1,904,311	\$ 53,205		\$ 58,096	\$ 4,891	\$ 283,265	36

<sup>\*</sup>Total beds on this schedule must agree with page 2.

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS

Page 12A 12/31/00 Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTER, LLC # 0041:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0041210 **Report Period Beginning:** 01/01/00 Ending:

Port   Port	_	1	ing Depreciation-Including Fixed Eqt	7	3	4 an numbers to near	5	6	7	1 8	1 9	
Beds			FOR OHE USE ONLY	Vear	Vear		Current Book	-	Straight Line		Accumulated	
S   S   S   S   S   S   S   S   S   S		Rode*	FOR OHF USE ONE I			Cost		-		Adjustments		
\$	4	Deus		Acquireu	Constructed	COST	e Depreciation	III 1 cars	e Depreciation	Aujustinents	Depreciation	+ 4
6	- 4					3	3		ð	3	3	
Toprovement Type**   Toprove	_											
S	_											
Improvement Type**												
9 REPAIR WALK-IN FREZ. 1997 1,348 35 20 67 32 268 99 10 SIGNS 1997 2,738 70 20 137 67 457 10 11 COOLER INSTALLATION 1997 3,448 88 20 172 84 688 11 12 LIGHT FIXTURES 1997 6,822 175 20 341 166 1,336 12 13 WALLCOVERINGS 1997 4,832 116 20 227 111 889 33 14 WALLCOVERINGS 1997 10,850 278 20 543 265 2,127 14 15 COOLER REPAIRS 1997 10,850 278 20 543 265 2,127 14 16 WASHER REPAIRS 1997 1,110 28 20 56 28 20 161 15 16 WASHER REPAIRS 1997 1,110 28 20 56 28 205 16 17 DINNG ROOM REMODEL 1997 1,110 28 20 56 28 205 16 18 IMPROVEMENT 1997 1,12396 318 20 620 302 2,480 18 19 (COMPRESSOR 1997 1,2396 318 20 620 302 2,480 18 19 (COMPRESSOR 1997 1,377 35 20 69 34 253 19 10 RINDS 1998 548 14 20 27 13 77 20 11 CARPET 1998 551 14 20 27 13 77 20 12 CARPETING 1998 551 14 20 27 13 77 22 14 CARPET 1998 1,337 27 20 355 163 997 22 14 IVAC REPAIRS 1998 1,337 27 20 52 25 147 24 18 PAC REPAIRS 1998 1,337 27 20 52 25 147 24 18 PAC REPAIRS 1998 1,524 39 20 76 37 222 25 14 IVAC REPAIRS 1998 1,524 39 20 76 37 222 25 14 IVAC REPAIRS 1998 1,524 39 20 76 37 222 25 14 IVAC REPAIRS 1998 1,524 39 20 76 37 222 25 14 IVAC REPAIRS 1998 1,524 39 20 76 37 222 25 14 IVAC REPAIRS 1998 1,524 39 20 76 37 222 25 14 IVAC REPAIRS 1998 1,524 39 20 76 37 222 25 14 IVAC REPAIRS 1998 1,524 39 20 76 37 222 25 14 IVAC REPAIRS 1998 1,524 39 20 76 37 222 25 14 IVAC REPAIRS 1998 1,524 39 20 76 37 222 25 14 IVAC REPAIRS 1998 1,524 39 20 76 37 222 25 14 IVAC REPAIRS 1998 1,524 39 20 76 37 222 25 14 IVAC REPAIRS 1998 1,524 39 20 76 37 222 25 14 IVAC REPAIRS 1998 1,524 39 20 76 37 222 25 15 IVAC LEANING 1998 1,524 39 20 59 29 177 31 15 IVAC LEANING 1998 1,524 39 20 59 29 177 31 15 IVAC LEANING 1998 1,524 39 20 59 29 177 31 15 IVAC LEANING 1998 1,524 39 20 59 29 177 31 17 IVAC LEANING 1998 1,524 39 20 59 29 177 31 18 IVAC LEANING 1998 1,524 39 20 59 29 177 31 18 IVAC LEANING 1998 1,524 39 20 59 29 177 31 18 IVAC LEANING 1998 1,524 39 20 59 29 39 177 31 18 IVAC LEANING 1998 1,524 39 20 47 25 35 39 39 39 20 17 IVAC LEANING 1998 1,524 39 30 24 47 23 39 90 34 18 IVAC LEANING 1998 1,44	8											8
10   SIGNS												
11   COOLER INSTALLATION   1997   3,448   88   20   172   84   688   11     12   LIGHT FIXTURES   1997   6,822   175   20   341   166   1,336   12     13   WALLCOVERINGS   1997   4,532   116   20   227   111   889   13     14   WALLCOVERINGS   1997   10,850   278   20   543   265   2,127   14     15   COOLER REPAIRS   1997   10,850   278   20   543   265   2,127   14     16   WASHER REPAIRS   1997   1,110   28   20   56   28   205   16     17   DINING ROOM REMODEL   1997   1,000   26   20   50   24   167   17     18   IMPROVEMENT   1997   1,377   35   20   620   302   2,480   18     19   COMPRESSOR   1997   1,377   35   20   69   34   253   19     19   COMPRESSOR   1997   1,377   35   20   69   34   253   19     21   CARPETING   1998   548   14   20   27   13   777   20     21   CARPETING   1998   6,709   172   20   335   163   977   22     22   CARPETING   1998   1,354   39   20   76   37   222   225     23   ACREPAIRS   1998   1,524   39   20   76   37   222   225     26   AUCREPAIRS   1998   3,186   20   159   159   398   22     26   AUCREPAIRS   1998   4,758   122   20   248   121   20   317   222     28   DIAGRERES   1998   3,186   20   159   159   398   22     27   AUCREPAIRS   1998   4,758   122   20   238   116   516   516   29     28   DAAPERIES   1998   4,758   122   20   238   116   516   516   29     29   DOOR GUARDS   1998   4,758   122   20   238   116   516   516   29     20   CARPETING   1998   4,758   122   20   238   116   516   516   29     20   AURING   1998   1,445   37   20   59   29   177   1,111   33     3   DAAPERIES   1999   1,445   37   20   47   23   39   34     3   DAAPERIES   1999   1,445   37   20   47   23   39   34     3   DAAPERIES   1999   1,445   37   20   20   38   18   76   33   35   35   36   36   36   36   3	9	REPAIR W	ALK-IN FREEZ		1997	1,348	35	20	67	32	268	9
12   LIGHT FIXTURES   1997												10
13   WALLCOVERINGS   1997					1 1					84		11
14 WALLCOVERINGS   1997   10,850   278   20   543   265   2,127   14   15   15   16   17   17   17   18   1997   1,110   28   20   56   28   205   16   15   16   17   17   17   17   18   18   18   18											,	12
15   COOLER REPAIRS   1997   820   21   20   41   20   161   15   16   WASHER REPAIRS   1997   1,110   28   20   56   28   205   16   197   1,100   26   20   50   24   167   17   18   IMPROVEMENT   1997   1,2396   318   20   620   302   2,480   18   19   1,377   35   20   69   34   253   19   1997   1,377   35   20   69   34   253   19   1998   548   14   20   27   13   77   20   20   28   14   84   21   22   24   24   20   24   20   24   24	13											13
16 WASHER REPAIRS   1997					1 1	10,850	278		543	265	2,127	14
17   DINING ROOM REMODEL   1997   1,000   26   20   50   24   167   17   18   IMPROVEMENT   1997   12,396   318   20   620   302   2,480   18   19   20   20   20   20   302   2,480   18   20   20   20   302   2,480   18   20   20   20   302   2,480   18   20   20   302   2,480   18   253   19   20   20   20   20   20   20   20   2	15				1 1				41			15
18   IMPROVEMENT   197												16
19											167	17
Description					1 1	,						18
CARPET   1998   551   14   20   28   14   84   21	19	COMPRES	SOR		1997	1,377	35		69	34	253	19
22 CARPETING       1998       6,709       172       20       335       163       977       22         23 AC REPAIRS       1998       823       21       20       41       20       109       23         24 HVAC REPAIRS       1998       1,037       27       20       52       25       147       24         25 BOILER REPAIRS       1998       1,524       39       20       76       37       222       25         26 A/C REPAIRS       1998       2,621       67       20       131       64       317       26         27 A/C CLEANING       1998       3,186       20       159       159       398       27         28 DRAPERIES       1998       4,758       122       20       248       121       599       28         29 DOOR GUARDS       1998       4,758       122       20       238       116       516       516       51       59       29       177       31       31 FLOORING       1998       1,177       30       20       59       29       177       31       32 CARPETING       1998       1,177       30       20       59       29       177       31       32<	20	BLINDS			1998		14		27	13	77	20
23 AC REPAIRS       1998       823       21       20       41       20       109       23         24 HVAC REPAIRS       1998       1,037       27       20       52       25       147       24         25 BOILER REPAIRS       1998       1,524       39       20       76       37       222       25         26 A/C REPAIRS       1998       2,621       67       20       131       64       317       26         27 A/C CLEANING       1998       3,186       20       159       159       398       26         28 DRAPERIES       1998       4,960       127       20       248       121       599       28         29 DOOR GUARDS       1998       4,758       122       20       238       116       516       29         30 ASPHAULT       1998       12,669       325       20       633       308       1,372       30         31 FLOORING       1998       1,177       30       20       59       29       177       31         32 CARPETING       1998       8,094       208       20       405       197       1,181       32         33 DRAPERIES       199							14					21
24 HVAC REPAIRS       1998       1,037       27       20       52       25       147       24         25 BOILER REPAIRS       1998       1,524       39       20       76       37       222       25         26 A/C REPAIRS       1998       2,621       67       20       151       64       317       26         27 A/C CLEANING       1998       3,186       20       159       159       398       27         28 DRAPERIES       1998       4,960       127       20       248       121       599       28         29 DOOR GUARDS       1998       4,758       122       20       238       116       516       29         30 ASPHAULT       1998       12,669       325       20       633       308       1,372       30         31 FLOORING       1998       1,177       30       20       59       29       177       31         32 CARPETING       1998       8,094       208       20       405       197       1,181       32         33 DRAPERIES       1999       1,445       37       20       72       35       96       33         34 VINYL WALLCOVERING							172		335	163		22
25 BOILER REPAIRS       1998       1,524       39       20       76       37       222       25         26 A/C REPAIRS       1998       2,621       67       20       131       64       317       26         27 A/C CLEANING       1998       3,186       20       159       159       398       27         28 DRAPERIES       1998       4,960       127       20       248       121       599       28         29 DOOR GUARDS       1998       4,758       122       20       238       116       516       29         30 ASPHAULT       1998       12,669       325       20       633       308       1,372       30         31 FLOORING       1998       1,177       30       20       59       29       177       31         32 CARPETING       1998       8,094       208       20       405       197       1,181       32         33 DRAPERIES       1999       1,445       37       20       72       35       96       33         34 VINYL WALLCOVERING       1999       764       20       20       38       18       76       35							21					23
26 A/C REPAIRS       1998       2,621       67       20       131       64       317       26         27 A/C CLEANING       1998       3,186       20       159       159       398       27         28 DRAPERIES       1998       4,960       127       20       248       121       599       28         29 DOOR GUARDS       1998       4,758       122       20       238       116       516       29         30 ASPHAULT       1998       12,669       325       20       633       308       1,372       30         31 FLOORING       1998       1,177       30       20       59       29       177       31         32 CARPETING       1998       8,094       208       20       405       197       1,181       32         33 DRAPERIES       1999       1,445       37       20       72       35       96       33         34 VINYL WALLCOVERING       1999       930       24       20       47       23       90       34         35 BOILER REPAIRS       1999       764       20       20       38       18       76       35												24
27 A/C CLEANING       1998       3,186       20       159       159       398       27         28 DRAPERIES       1998       4,960       127       20       248       121       599       28         29 DOOR GUARDS       1998       4,758       122       20       238       116       516       29         30 ASPHAULT       1998       12,669       325       20       633       308       1,372       30         31 FLOORING       1998       1,177       30       20       59       29       177       31         32 CARPETING       1998       8,094       208       20       405       197       1,181       32         33 DRAPERIES       1999       1,445       37       20       72       35       96       33         34 VINYL WALLCOVERING       1999       930       24       20       47       23       90       34         35 BOILER REPAIRS       1999       764       20       20       38       18       76       35												
28 DRAPERIES       1998       4,960       127       20       248       121       599       28         29 DOOR GUARDS       1998       4,758       122       20       238       116       516       29         30 ASPHAULT       1998       12,669       325       20       633       308       1,372       30         31 FLOORING       1998       1,177       30       20       59       29       177       31         32 CARPETING       1998       8,094       208       20       405       197       1,181       32         33 DRAPERIES       1999       1,445       37       20       72       35       96       33         34 VINYL WALLCOVERING       1999       930       24       20       47       23       90       34         35 BOILER REPAIRS       1999       764       20       20       38       18       76       35							67					26
29 DOOR GUARDS     1998     4,758     122     20     238     116     516     29       30 ASPHAULT     1998     12,669     325     20     633     308     1,372     30       31 FLOORING     1998     1,177     30     20     59     29     177     31       32 CARPETING     1998     8,094     208     20     405     197     1,181     32       33 DRAPERIES     1999     1,445     37     20     72     35     96     33       34 VINYL WALLCOVERING     1999     930     24     20     47     23     90     34       35 BOILER REPAIRS     1999     764     20     20     38     18     76     35						- /						27
30 ASPHAULT     1998     12,669     325     20     633     308     1,372     30       31 FLOORING     1998     1,177     30     20     59     29     177     31       32 CARPETING     1998     8,094     208     20     405     197     1,181     32       33 DRAPERIES     1999     1,445     37     20     72     35     96     33       34 VINYL WALLCOVERING     1999     930     24     20     47     23     90     34       35 BOILER REPAIRS     1999     764     20     20     38     18     76     35												28
31 FLOORING     1998     1,177     30     20     59     29     177     31       32 CARPETING     1998     8,094     208     20     405     197     1,181     32       33 DRAPERIES     1999     1,445     37     20     72     35     96     33       34 VINYL WALLCOVERING     1999     930     24     20     47     23     90     34       35 BOILER REPAIRS     1999     764     20     20     38     18     76     35												29
32 CARPETING     1998     8,094     208     20     405     197     1,181     32       33 DRAPERIES     1999     1,445     37     20     72     35     96     33       34 VINYL WALLCOVERING     1999     930     24     20     47     23     90     34       35 BOILER REPAIRS     1999     764     20     20     38     18     76     35											· · · · · · · · · · · · · · · · · · ·	30
33 DRAPERIES     1999     1,445     37     20     72     35     96     33       34 VINYL WALLCOVERING     1999     930     24     20     47     23     90     34       35 BOILER REPAIRS     1999     764     20     20     38     18     76     35	-					,						31
34 VINYL WALLCOVERING         1999         930         24         20         47         23         90         34           35 BOILER REPAIRS         1999         764         20         20         38         18         76         35	-					- /	208		405	197	1,181	32
35 BOILER REPAIRS 1999 764 20 20 38 18 76 35												33
											90	34
36 TOTAL (lines 4 thru 35)	35	BOILER R	EPAIRS		1999	764	20	20	38	18	76	35
	36	TOTAL (lin	ies 4 thru 35)			\$ 98,237	\$ 2,437		\$ 4,912	\$ 2,475	\$ 15,469	36

<sup>\*</sup>Total beds on this schedule must agree with page 2.

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12B 12/31/00 Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTER, LLC # 0041
XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0041210 **Report Period Beginning:** 01/01/00 Ending:

D,	Building Depreciation-Including Fixed Equ	npment. (See instr	uctions.) Round		rest donar.	,				
1	EOD OHE HEE ONLY	2	3	4	5 . D . I	6	G. 141.	8	9,,,	
	FOR OHF USE ONLY	Year	Year	_	Current Book	Life	Straight Line		Accumulated	
Bed	ds*	Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									_
9 DRAP	PERIES		1999	826	21	20	41	20	75	9
	L WALLCOVERING		1999	1,788	46	20	89	43	119	10
11 DRAP	PES		1999	696	18	20	35	17	41	11
12 WALI	LPAPER		1999	4,780	123	20	239	116	279	12
13 WALI			1999	2,200	56	20	110	54	119	13
14 A/C R	REPAIRS		1999	7,686		20	384	384	608	14
	LPAPER BORDERS		1999	759	19	20	38	19	44	15
	LPAPER BORDERS		2000	2,374	48	20	99	51	99	16
	PERIES		2000	4,165	67	20	139	72	139	17
	L WALLCOVERING		2000	2,754	62	20	127	65	127	18
	ALL VINL 27 ROOMS		2000	1,722		20	86	86	86	19
	947 EXHAUST FAN		2000	1,198		20	45	45	45	20
21 CHIL	LER		2000	29,619	5,924	20	864	(5,060)	864	21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35 more	1 (1) (1)				6.20		2.205	(4.000)	2 :	35
36  TOTA	AL (lines 4 thru 35)			\$ 60,567	\$ 6,384		\$ 2,296	\$ (4,088)	\$ 2,645	36

<sup>\*</sup>Total beds on this schedule must agree with page 2.

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12C 12/31/00 Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTER, LLC # 0041
XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0041210 **Report Period Beginning:** 01/01/00 Ending:

	b. Buildin	ig Depreciation-Including Fixed Eq		uctions.) Round							
	1		2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
_	Impro	vement Type**									
9	p. v	, ement 1, pe				T	1				9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (line	s 4 thru 35)			\$	\$		\$	\$	\$	36

<sup>\*</sup>Total beds on this schedule must agree with page 2.

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12D 12/31/00 Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTER, LLC # 0041
XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0041210 **Report Period Beginning:** 01/01/00 Ending:

	b. Buildin	ig Depreciation-Including Fixed Eq		uctions.) Round							
	1		2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
_	Impro	vement Type**									
9	p. v	tement 1, pe				T	1				9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (line	s 4 thru 35)			\$	\$		\$	\$	\$	36

<sup>\*</sup>Total beds on this schedule must agree with page 2.

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12E 12/31/00 Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTER, LLC # 0041
XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0041210 **Report Period Beginning:** 01/01/00 Ending:

	B. Bullair	ig Depreciation-Including Fixed Equ									
	1		2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Impro	vement Type**									
9	F -	J.F.									9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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24											24
25											25
26											26
27											27
28											28 29
29 30											30
31 32											31 32
33											33
34											34
35											35
	TOTAL (!:-:	s 4 thun 35)			6	6		S	•	S	
30	ГОТАL (line	8 4 tilru 33)			\$	\$		3	\$	Þ	36

<sup>\*</sup>Total beds on this schedule must agree with page 2.

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12F 12/31/00 Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTER, LLC # 0041
XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0041210 **Report Period Beginning:** 01/01/00 Ending:

	b. Buildin	ig Depreciation-Including Fixed Eq		uctions.) Round							
	1		2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
_	Impro	vement Type**									
9	p. v	tement 1, pe				T	1				9
10											10
11											11
12											12
13											13
14											14
15											15
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (line	s 4 thru 35)			\$	\$		\$	\$	\$	36

<sup>\*</sup>Total beds on this schedule must agree with page 2.

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12G 12/31/00 Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTER, LLC # 0041
XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0041210 **Report Period Beginning:** 01/01/00 Ending:

	B. Bullair	ig Depreciation-Including Fixed Equ									
	1		2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Impro	vement Type**									
9	F -	J.F.									9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
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18											18
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26											26
27											27
28											28 29
29 30											30
31 32											31 32
33											33
34											34
35											35
	TOTAL (!:-:	s 4 thun 35)			6	6		S	•	S	
30	ГОТАL (line	8 4 tilru 33)			\$	\$		3	\$	Þ	36

<sup>\*</sup>Total beds on this schedule must agree with page 2.

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12H 12/31/00 Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTER, LLC # 0041

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar. # 0041210 **Report Period Beginning:** 01/01/00 Ending:

	B. Bullair	ıg Depreciation-Including Fixed Eqı	uipment. (See instr	uctions.) Kound	all numbers to nea	rest dollar.					
	1		2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	Deas		riequireu	Constructed	\$	\$	111 1 (111)	\$	s c	s precinción	4
5					J.	9		Ψ	J.	U)	5
-											
6											6
7											7
8											8
	Impro	vement Type**									
9											9
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17											17
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30								<b> </b>			30
31								1			31
32											32
33											33
34								ļ			34
35											35
36	TOTAL (line	s 4 thru 35)			\$	\$		\$	\$	\$	36

<sup>\*</sup>Total beds on this schedule must agree with page 2.

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12I 12/31/00 Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTER, LLC # 0041
XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0041210 **Report Period Beginning:** 01/01/00 Ending:

	b. Buildin	ig Depreciation-Including Fixed Eq		uctions.) Round							
	1		2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
_	Impro	vement Type**									
9	p. v	tement 1, pe				T	1				9
10											10
11											11
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (line	s 4 thru 35)			\$	\$		\$	\$	\$	36

<sup>\*</sup>Total beds on this schedule must agree with page 2.

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12J 12/31/00 Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTER, LLC # 0041

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar. # 0041210 **Report Period Beginning:** 01/01/00 Ending:

	B. Bullair	ıg Depreciation-Including Fixed Eqı	uipment. (See instr	uctions.) Kound	all numbers to nea	rest dollar.					
	1		2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	Deas		riequireu	Constructed	\$	\$	111 1 (111)	\$	s c	s precinción	4
5					J.	9		Ψ	J.	U)	5
-											
6											6
7											7
8											8
	Impro	vement Type**									
9											9
10											10
11											11
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30								<b> </b>			30
31								1			31
32											32
33											33
34								ļ			34
35											35
36	TOTAL (line	s 4 thru 35)			\$	\$		\$	\$	\$	36

<sup>\*</sup>Total beds on this schedule must agree with page 2.

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12-1 REP 12/31/00 Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTER, LLC # 0041

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar. # 0041210 Report Period Beginning: 01/01/00 Ending:

	B. Bullair	ıg Depreciation-Including Fixed Eqı	uipment. (See instr	uctions.) Kound	all numbers to nea	rest dollar.					
	1		2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	Deas		riequireu	Constructed	\$	\$	111 1 (111)	\$	s c	s precinción	4
5					J.	9		Ψ	J.	U)	5
-											
6											6
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8											8
	Impro	vement Type**									
9											9
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29								-			29
30								<b> </b>			30
31								1			31
32											32
33											33
34								ļ			34
35											35
36	TOTAL (line	s 4 thru 35)			\$	\$		\$	\$	\$	36

<sup>\*</sup>Total beds on this schedule must agree with page 2.

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12-2 REP 12/31/00 Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTER, LLC # 0041
XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0041210 **Report Period Beginning:** 01/01/00 Ending:

	b. Buildin	ig Depreciation-Including Fixed Eq		uctions.) Round							
	1		2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
_	Impro	vement Type**									
9	p. v	tement 1, pe				T	1				9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (line	s 4 thru 35)			\$	\$		\$	\$	\$	36

<sup>\*</sup>Total beds on this schedule must agree with page 2.

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 13 **Report Period Beginning:** Facility Name & ID Number ELMWOOD NURSING & REHABILITATION (# 0041210 12/31/00 01/01/00 **Ending:** 

### XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of	1	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation	6
37	Purchased in Prior Years	\$ 270,107	\$ 30,936	\$ 27,988	\$ (2,948)		\$ 133,091	37
38	Current Year Purchases	10,294	2,059	461	(1,598)		461	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 280,401	\$ 32,995	\$ 28,449	\$ (4,546)		\$ 133,552	41

D. Vehicle Depreciation (See instructions.)\*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

	E. Summary of Care-Related Assets	1	2		
		Reference	Amount		Ī
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 2,369,607	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 86,200	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 86,545	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 345	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 416,817	51	1

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

# ELMWOOD NURSING & REHABILITATION CENTER, LLC 0041210 RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE 12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
Olin All Halie		BEITEOIATION	DEFREGIATION	ADOUGHNERTO	DEFREGIATION
LINE 28: PRIOR YEARS					
ELMWOOD NURSING & REHABILITATION CENTER, LLC	56,603	11,706	6,637	(5,069)	20,108
MARYVILLE HEALTHCARE PROPERTIES	208,000	18,282	20,800	2,518	109,200
HEALTHCARE MANAGEMENT ASSOCIATES	5,504	948	551	(397)	3,783
TOTALS	270,107	30,936	27,988	(2,948)	133,091
LINE 29: CURRENT YEAR					
ELMWOOD NURSING & REHABILITATION CENTER, LLC	10,294	2,059	461	(1,598)	461
MARYVILLE HEALTHCARE PROPERTIES HEALTHCARE MANAGEMENT ASSOCIATES					
TOTALS	10,294	2,059	461	(1,598)	461
ELMWOOD NURSING & REHABILITATION CENTER, LLC MARYVILLE HEALTHCARE PROPERTIES HEALTHCARE MANAGEMENT ASSOCIATES					
TOTALS					
TOTALS (Should Tie to Totals on Page 13)					
ELMWOOD NURSING & REHABILITATION CENTER, LLC	66,897	13,765	7,098	(6,667)	20,569
MARYVILLE HEALTHCARE PROPERTIES	208,000	18,282	20,800	2,518	109,200
HEALTHCARE MANAGEMENT ASSOCIATES	5,504	948	551	(397)	3,783
TOTALS	280,401	32,995	28,449	(4,546)	133,552

NO

VII	RENT	LV	COST	ΓÇ

A. Building a	and Five	d Equinma	ent (See	instruction	e )
A. Dununny 2	mu rixe	a raunome	ani toee	mistraction	S. I

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
	Original							
3	<b>Building:</b>				\$			3
4	Additions	•						4
5	ALLOCATE-	-HMA			5,831			5
6								6
7	TOTAL				\$ 5,831			7

8. List separately any This amount was o by the length of th	alculated by			10	,	<u>-</u> -
O. Option to Buy:		YES	NO NO	O Terms:	:	*

В	. I	₫q	u	ipi	me	nt	-E	xclu	ıdir	ıg ˈ	I ra	nsp	001	rta	tio	n	ano	1 F	ixe	d Ł	Equipment	. (See	ins	tructi	ons.

15. Is Movable equipment rental included in building rental?

16. Rental Amount for movable equipment: \$ 15,427

YES

Description: COPIER \$6,808; OXYGEN \$3,329; POSTAGE METER \$116; STORAGE UNIT \$200; ALLOC-HMA \$4,974 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ALLOC - HMA		\$	\$ 1,364	17
18					18
19					19
20					20
21	TOTAL		<b>\$</b>	\$ 1,364	21

- 10. Effective dates of current rental agreement: Beginning Ending
- 11. Rent to be paid in future years under the current rental agreement:

Fiscal Ye	ar Ending	<b>Annual Rent</b>	
12.	/2001	\$	
13.	/2002	\$	
14.	/2003	S	

- \* If there is an option to buy the building, please provide complete details on attached schedule.
- \*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO NURSE AIDE TRAININ	`	,			
A. TYPE OF TRAINING PROGRAM (If aides are tra  1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	ined in another facility  YES 2  X NO	• •	I PORTION:	the facility name, ad	3. CLINICAL PORTION: IN-HOUSE PROGRAM
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.		IN OTHER FA	Y COLLEGE		IN OTHER FACILITY HOURS PER AIDE
B. EXPENSES	ALLOCATI	ON OF COSTS	(d)		C. CONTRACTUAL INCOME  In the box below record the amount of income your
	Fa Drop-outs	cility  Completed	Contract	4 Total	facility received training aides from other facilities.
1 Community College Tuition 2 Books and Supplies	\$	\$	\$	\$	D. NUMBER OF AIDES TRAINED
3 Classroom Wages (a) 4 Clinical Wages (b)					COMPLETED
5 In-House Trainer Wages (c) 6 Transportation					1. From this facility 2. From other facilities (f)
7 Contractual Payments 8 Nurse Aide Competency Tests					DROP-OUTS 1. From this facility
9 TOTALS 10 SUM OF line 9, col. 1 and 2 (e)	\$ \$	\$	\$	\$	2. From other facilities (f) TOTAL TRAINED

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

# 0041210

Report Period Beginning:

01/01/00 Ending: Page 16 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

Facility Name & ID Number

		1	2	3	4	5	6	7	8	
		Schedule V	Staf	f	Outsid	e Practitioner	Supplies			
	Service	Line & Column	Units of	Cost	(other tl	han consultant)	(Actual or)	Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. $3 + 5 + 6$ )	
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 57,776	\$	\$	57,776	1
	Licensed Speech and Language									
2	Development Therapist	39-3	hrs			8,128			8,128	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			69,814			69,814	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy	39-2	prescrpts				36,871		36,871	9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
	**SEE SUPPLEMENTAL									
13	Other (specify): SCHEDULE**						16,707		16,707	13
									·	
14	TOTAL			\$		\$ 135,718	\$ 53,578	\$	189,296	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTER, LLC STATE OF ILLINOIS Page 16 - SUPP Facility Name & ID Number Facility Name & ID Number Period Beginning: 01/01/00 Ending: 12/31/00

### SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

Special Services - Supplies (Column 6 - Other)	Amount
1 Medical Supplies 2 Complex Medical Equip	10,095
3 Oxygen	
4 Equipment Rental	
5 AIR BEDS	1,564
6 LABORATORY & X-RAY	5,048
7	- 7-
8	
9	
10	
	16,707
Outside Therapies (Column 5 - Other)	Amount
1 Respiratory Therapy	
2	
3	
4	
5	
6	
7	
8	
9	
10	

(last day of reporting year)

Page 17 0041210 Report Period Beginning: ELMWOOD NURSING & REHABILITATION CENTER, # 01/01/00 12/31/00 Facility Name & ID Number **Ending:** 

XV. BALANCE SHEET - Unrestricted Operating Fund.
This report must be completed even if financial statements are attached. As of 12/31/00

	This report must be completed even	if fin	ancial stateme			
		1			2 After	
		О	perating	C	onsolidation*	
	A. Current Assets					
1	Cash on Hand and in Banks	\$	50,836	\$	53,497	1
2	Cash-Patient Deposits					2
	Accounts & Short-Term Notes Receivable					
3	Patients (less allowance )		376,159		376,159	3
4	Supply Inventory (priced at )					4
5	Short-Term Investments					5
6	Prepaid Insurance		70,896		70,896	6
7	Other Prepaid Expenses		1,454		1,454	7
8	Accounts Receivable (owners or related parties)		587,326		610,326	8
9	Other(specify): See supplemental schedule		11,228		11,228	9
	TOTAL Current Assets					
10	(sum of lines 1 thru 9)	\$	1,097,899	\$	1,123,560	10
	B. Long-Term Assets					
11	Long-Term Notes Receivable					11
12	Long-Term Investments					12
13	Land				184,895	13
14	Buildings, at Historical Cost				1,698,087	14
15	Leasehold Improvements, at Historical Cos		151,132		151,132	15
16	Equipment, at Historical Cost		105,881		313,881	16
17	Accumulated Depreciation (book methods)		(65,155)		(467,937)	17
18	Deferred Charges					18
19	Organization & Pre-Operating Costs					19
	Accumulated Amortization -					
20	Organization & Pre-Operating Costs					20
21	Restricted Funds					21
22	Other Long-Term Assets (specify):					22
23	Other(specify): See supplemental schedule					23
	TOTAL Long-Term Assets					
24	(sum of lines 11 thru 23)	\$	191,858	\$	1,880,058	24

1,289,757

TOTAL ASSETS

25 (sum of lines 10 and 24)

		1	perating		2 After Consolidation*	
	C. Current Liabilities					
26	Accounts Payable	\$	932,167	\$	932,167	26
27	Officer's Accounts Payable		195,891		195,891	27
28	Accounts Payable-Patient Deposits		965		965	28
29	Short-Term Notes Payable		200,000		200,000	29
30	Accrued Salaries Payable		60,598		60,598	30
	Accrued Taxes Payable					
31	(excluding real estate taxes)		6,270		6,270	3
32	Accrued Real Estate Taxes(Sch.IX-B)		38,000		38,000	32
33	Accrued Interest Payable					3.
34	Deferred Compensation					34
35	Federal and State Income Taxes					3:
	Other Current Liabilities(specify):					
36	See supplemental schedule					30
37						3′
	TOTAL Current Liabilities					
38	(sum of lines 26 thru 37)	\$	1,433,891	\$	1,433,891	38
	D. Long-Term Liabilities					
39	Long-Term Notes Payable					39
40	Mortgage Payable				1,631,172	4
41	Bonds Payable					4
42	Deferred Compensation					42
	Other Long-Term Liabilities(specify):					
43	See supplemental schedule					43
44						44
	TOTAL Long-Term Liabilities					
45	(sum of lines 39 thru 44)	\$		\$	1,631,172	4
	TOTAL LIABILITIES			1		1
46	(sum of lines 38 and 45)	\$	1,433,891	\$	3,065,063	40
			,,	Ť	,,	1
47	TOTAL EQUITY(page 18, line 24)	\$	(144,134)	\$	#REF!	4
	TOTAL LIABILITIES AND EQUITY		(,)	-		Ť
48	(sum of lines 46 and 47)	<b> </b> \$	1,289,757	\$	#REF!	48

\*(See instructions.)

25

3,003,618

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STATE	OF I	111	INUIS	,

Page 17 SUPP-1

Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTE# 0041210 **Report Period Beginning: 01/01/00** 12/31/00 **Ending:** SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES As of 12/31/00 OTHER CURRENT ASSETS: OTHER CURRENT LIABILITIES: Amount Amount Amount Amount Real Estate Tax Escrow 11,228 11,228 11,228 11,228 OTHER NON CURRENT ASSETS: OTHER NON CURRENT LIABILITIES: Construction In Progress Utility Deposit Loan Costs

Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTER, LLC XVI. STATEMENT OF CHANGES IN EQUITY

0041210

**Report Period Beginning:** 01/01/00

12/31/00

**Ending:** 

			1 Total	
-	DI AD'' CV D'ID AI	0		4
2	Balance at Beginning of Year, as Previously Reported	\$	223,697	1
	Restatements (describe):			2
3	Schedule attached			3
4				4
5				5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	223,697	6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		(546,569)	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants		178,738	11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	(	)	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe)			15
16	Other (describe)			16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	(367,831)	17
	B. Transfers (Itemize):			
18				18
19				19
20				20
21				21
22				22
23	TOTAL Transfers (sum of lines 18-22)	\$		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	(144,134)	24

<sup>\*</sup> This must agree with page 17, line 47.

Facility Name & ID Number ELMWOOD NURSING & REHABILIT#	0041210	Report Period Beginning:	01/01/00	Ending:	12/31/00
Balance per General Ledger Adjustments:		223,697			
		-			
		-			
Total adjustments		<u>-</u>			
		·			
Balance - Beginning of Year		223,697			
Equity(Deficit) from Page 17 Col 1		(144,134)			
Related Party					
Equity(Deficit) Income	-81484 164173				
		82,689			
Combined Equity - End of Year		(61,445)			

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue		Amount	
	A. Inpatient Care		Amount	
1	Gross Revenue All Levels of Care	\$	3,124,488	1
2	Discounts and Allowances for all Levels	Þ	(171,775)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$	2,952,713	3
3		3	2,952,713	٥
4	B. Ancillary Revenue			4
5	Day Care			5
_	Other Care for Outpatients		192,930	_
6	Therapy		192,930	6
7	Oxygen		102.020	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	192,930	8
	C. Other Operating Revenue			
9	Payments for Education			9
10	Other Government Grants			10
11	Nurses Aide Training Reimbursements			11
12	Gift and Coffee Shop			12
13	Barber and Beauty Care		646	13
14	Non-Patient Meals			14
15	Telephone, Television and Radic			15
16	Rental of Facility Space			16
17	Sale of Drugs		28,431	17
18	Sale of Supplies to Non-Patients			18
19	Laboratory		4,926	19
20	Radiology and X-Ray		1,743	20
21	Other Medical Services		21,108	21
22	Laundry			22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22	\$	56,854	23
	D. Non-Operating Revenue			
24	Contributions			24
25	Interest and Other Investment Income***		13,433	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	13,433	26
	E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)			27
28	See supplemental schedule		1,594	28
28a			, , , , , , , , , ,	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	1,594	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$	3,217,524	30

		Z	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	570,762	31
32	Health Care	1,364,494	32
33	General Administration	1,095,948	33
	B. Capital Expense		
34	Ownership	486,497	34
	C. Ancillary Expense		
35	Special Cost Centers	189,296	35
36	Provider Participation Feε	57,096	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,764,093	40
41	Income before Income Taxes (line 30 minus line 40)**	(546,569)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (546,569)	43

*	This must	agree with	page 4, line 4	5. column 4

2

Does this agree with taxable income (loss) per Federal Income If not, please attach a reconciliation. Tax Return?

<sup>\*\*\*</sup> See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

<sup>\*\*\*\*</sup>Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facilit		ELMWOOD NURSING & REHABI	STATE OF ILLINOIS # 0041210	Report Period Beginning:	01/01/00	Ending:	Page 19 - SUPP 12/31/00
	SUPPLEMENTAL SCI	HEDULE OF REVENUES					
	12/31/00						
	DESCRIPTION		AMOUNT				
1	Vending Commissions		1,594				
2							
3							
4	ļ						
5	;						
6	, )						
7	1						
8	3						
9	)						
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
19	•						

TOTALS

20

## Facility Name & ID Number ELMWOOD NURSING & REHABILITATION ( XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.) (This schedule must cover the entire reporting period.)

	(This schedule must cover the	e entire reportin	g period.) 2**	3	4	
	1	# of Hrs.	# of Hrs.	Reporting Period	Average	
		Actually	Paid and	Total Salaries,	Hourly	
		Worked	Accrued	Wages	Wage	
1	Discotor of Nameiro	2,080	2,088	\$ 49,018	\$ 23.48	1
2	Director of Nursing				20.81	2
3	Assistant Director of Nursing	2,080	2,088	43,461	16.12	3
	Registered Nurses Licensed Practical Nurses	7,987	8,852	142,689		
4		21,926	25,181	336,422	13.36	4
5	Nurse Aides & Orderlies	74,819	79,815	573,070	7.18	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,843	5,381	37,560	6.98	10
11	Social Service Workers	5,722	6,414	51,886	8.09	11
12	Dietician					12
	Food Service Supervisor					13
14	Head Cook					14
	Cook Helpers/Assistants	18,115	18,526	119,489	6.45	15
	Dishwashers					16
17	Maintenance Workers	3,904	4,051	43,100	10.64	17
18	Housekeepers	14,863	15,167	87,360	5.76	18
19	Laundry	6,263	6,390	37,639	5.89	19
20	Administrator	2,080	2,169	51,073	23.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,769	5,887	51,338	8.72	24
25	Vocational Instruction		,	,		25
_	Academic Instruction					26
27	Medical Director	1				27
	Qualified MR Prof. (QMRP)	1				28
29	Resident Services Coordinator	1				29
30	Habilitation Aides (DD Homes)	†				30
31	Medical Records	2,625	2,641	22,076	8.36	31
32	Other Health Care(specify)	2,020	2,0.11	22,070	0.00	32
33	Other(specify)	0	0	0	+	33
33	Other (specify)	+ •	U	U	<b>+</b>	33

173,076

184,650

34 TOTAL (lines 1 - 33)

1,646,181 \*

34

8.92

### B. CONSULTANT SERVICES

		1	2	3	
		Number	<b>Total Consultant</b>	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant	16	\$ 5,327	1-3	35
36	Medical Director	MONTHLY	12,000	9-3	36
37	Medical Records Consultant	4	140	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	54	2,439	11-3	44
45	Social Service Consultant	69	4,253	12-3	45
46	Other(specify)				46
47	PSYCHO-SOCIAL CONSULTANT	60	3,751	12-3	47
48					48
49	TOTAL (lines 35 - 48)	203	\$ 27,910		49

### C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

<sup>\*</sup> This total must agree with page 4, column 1, line 45.

<sup>\*\*</sup> See instructions.

	STATE OF ILLI	NOIS		Page 20 - SUPP
Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTER, LLC	# 0041210	Report Period Beginning: 01/01/00	Ending:	12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. # of Hrs. Reporting Period Average
Actually Paid and Wages Wage

\$ \$ \$

STATE OF ILLINOIS Page 21

Facility Name & ID Number	ELMWOOD NURSING	G & REHA	BILITATION (	# 0041210		Report Per	riod Beginning: 01/01/00 Endin	g: 12/31/00
XIX. SUPPORT SCHEDULES								
A. Administrative Salaries		Ownership		D. Employee Benefits and Payrol			F. Dues, Fees, Subscriptions and Promot	
Name	Function	<b>%</b>	Amount	Description		Amou		Amount
MARY WOOD	ADMINISTRATOR	0	\$ 51,073	Workers' Compensation Insuran		\$ 53,4		<b>\$</b> 200
				<b>Unemployment Compensation In</b>	surance	32,7		2,870
				FICA Taxes		124,7		
				Employee Health Insurance		18,7	(Indicate # of checks performed 45	) 450
				Employee Meals		3,3	PROMOTIONAL ADVERTISING	2,400
				Illinois Municipal Retirement Fu	nd (IMRF)*		DUES & SUBSCRIPTIONS	270
	<u> </u>			EMPLOYEE BENEFITS		14,0	DICENSES & FEES	1,765
TOTAL (agree to Schedule V, lin	ne 17, col. 1)						YELLOW PAGES	1,699
(List each licensed administrator	separately.)		\$ 51,073				ALLOCATED-HMA	348
B. Administrative - Other			-					
							Less: Public Relations Expense	()
Description			Amount				Non-allowable advertising	(2,400)
MANAGEMENT FEES-MARK	SUISSA		\$ 38,640				Yellow page advertising	(1,699)
MANAGEMENT FEES-ERIC R			38,640					
MANAGEMENT FEES-DAVID			6,720	TOTAL (agree to Schedule V,		\$ 247,1	TOTAL (agree to Sch. V,	\$ 5,903
HOME OFFICE EXPENSES			150,000	line 22, col.8)		· · · · · · · ·	line 20, col. 8)	· <del></del>
TOTAL (agree to Schedule V, lin	ne 17, col. 3)		\$ 234,000	E. Schedule of Non-Cash Compe	nsation Paid		G. Schedule of Travel and Seminar**	
(Attach a copy of any manageme				to Owners or Employees				
C. Professional Services	ne ser vice agreement)			to o where or Employees			Description	Amount
Vendor/Payee	Type		Amount	Description	Line #	Amou	<u>-</u>	
FR&R	ACCOUNTING		\$ 25,349	Description	Eine "	\$	Out-of-State Travel	\$
BKD	ACCOUNTING		11,351			_	Out-01-State 11avei	. "
VARIOUS (SEE ATTACHED)	LEGAL		192,810		-			-
THRESHOLD DATA	DATA PROCESSI	NC	1,500		-		In-State Travel	-
CARE COMPUTERS	DATA PROCESSI		2,375		-		III-State Traver	-
PERSONNELL PLANNERS	UC TAX CONSUL		1,287		-			· ——
TERSONNELL FLANNERS	UC TAA CONSUL	TANI	1,207	-		<del>-</del>		-
							Seminar Expense	1 150
			<u> </u>				ALLOCATED-HMA	1,159 247
					-		ALLOCATED-HMA	
								<u> </u>
							The state of the s	· , ———,
TOTAL ( A S.I. I. XX P.	10 1 2)			TOTAL		0	Entertainment Expense	_ ()
TOTAL (agree to Schedule V, lin			0 224 (50	TOTAL		\$	(agree to Sch. V,	0 1400
(If total legal fees exceed \$2500 a	ttach copy of invoices.)		\$ 234,672				TOTAL line 24, col. 8)	\$ 1,406

<sup>\*</sup> Attach copy of IMRF notifications

<sup>\*\*</sup>See instructions.

Page 22 Facility Name & ID Number ELMWOOD NURSING & REHABILITATION CENTER Report Period Beginning: **Ending:** 01/01/00 12/31/00 0041210

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3). (See instructions.)

	1	2		3	4	:	5		6		7		8		9	10	11	12	13
		Month & Year										A	Amount of l	Exper	ıse Amorti	zed Per Year			
	Improvement Type	Improvement Was Made	To	otal Cost	Useful Life	FY	1997	F	Y1998	F	Y1999	]	FY2000	F	Y2001	FY2002	FY2003	FY2004	FY2005
1	PAINTING & DÉCOR	6/97	\$	8,565	3	\$ 1	,428	\$	2,855	\$	2,855	\$	1,427	\$		\$	\$	\$	\$
2																			
3																			
4																			
5																			
6																			
7																			
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17																			
18				· ·							· ·								
19				· ·							· ·								
20	TOTALS		\$	8,565		\$ 1.	,428	\$	2,855	\$	2,855	\$	1,427	\$		\$	\$	\$	\$

Facility	y Name & ID Number ELMWOOD NURSING & REHABILITATION CENTER, LLC	STATE OF ILLINOIS  # 0041210
	ENERAL INFORMATION:	" ovii 210 Report I eriou Beginningi ori/ori/ov Bhumgi 12/01/o
	Are nursing employees (RN,LPN,NA) represented by a union NO	(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified
(2)	Are there any dues to nursing home associations included on the cost report.  NO  If YES, give association name and amount.	in the Ancillary Section of Schedule V? YES
(3)	Did the nursing home make political contributions or payments to a politica action organization? NO If YES, have these costs been properly adjusted out of the cost report?	(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attact a schedule which explains how all related costs were allocated to these functions
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?	(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 3,338 Has any meal income been offset against related costs? N/A Indicate the amount. \$
(5)	Have you properly capitalized all major repairs and equipment purchases:  What was the average life used for new equipment added during this period?  YES  10	(16) Travel and Transportation
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 330 Line 10	a. Are there costs included for out-of-state travel?  If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents?  NO If YES, please indicate the amount of income earned from such a
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports?   YES If NO, attach a complete explanation.	program during this reporting period. \$  c. What percent of all travel expense relates to transportation of nurses and patients. NO  d. Have vehicle usage logs been maintained? N/A
(8)	Are you presently operating under a sale and leaseback arrangement.  NO  If YES, give effective date of lease.	e. Are all vehicles stored at the nursing home during the night and all othe times when not in use?  N/A  f. Has the cost for commuting or other personal use of autos been adjusted
(9)	Are you presently operating under a sublease agreement YES X NO	out of the cost report? N/A  g. Does the facility transport residents to and from day training? NO
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over	Indicate the amount of income earned from providing such
		(17) Has an audit been performed by an independent certified public accounting firm? NO  Firm Name: The instructions for the second control of the control o
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 57,096  This amount is to be recorded on line 42 of Schedule V	cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?  NO If YES, attach an explanation of the allocation.	(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? YES
	<u> </u>	(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?  Attach invoices and a summary of services for all architect and appraisal fees.

07/17/2000

Administrator/Cost Report Preparer

From: Office of Health Finance

2000 Long Term Care Cost Report and Instructions on Diskette

Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would apprecia it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fisca year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, whichever comes later. Please refer to the instructions for the remaind of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to ent the IDPH licensed name of the facility.) When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 1 do not enter various or other text in columns 2 or 3.

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or ". Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. Please do not reduce the image to 8 1/2 by 11. We cannot accept a report with an 8 1/2 by 11 image. After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records). Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users
The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. Only use these commands on the extra pages (24 through 33). The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and ther ensure the file type is "WK4".

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them

### Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23"

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-

RH/cw